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ABSTRACT

This resource book, which provides an overview of the people and resources of the fictious state of Gerontopia, is designed to serve as a simulation device for policy and program planning. By helping students examine the conditions and needs of older adults, the materials can be used to generate ideas, suggest alternatives to existing service strategies, and facilitate the process of experiential learning. The appendices include descriptions of projects designed to enhance the well-being of the elderly, a list of professional organizations, and state and national data sources. (JAC)

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Gerontopia

An Aging Resource Book

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December 1980

Department of Health Administration
School of Public Health
University of North Carolina at Chapel Hill

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Foreword

The aging of our population has many serious health implications and the dimensions of the problems are expected to increase in the coming decades. Most of the health needs of older people can most effectively be met through organized collective action, but to plan, develop and administer health programs for the elderly more personnel with competence in public health are required.

Schools of Public Health in general have paid little attention to the field of aging and the contribution they can make to it. Nevertheless within these institutions there are the academic resources which could eventually enhance the well being of our aging citizens. With relatively minor changes in existing teaching and research programs, the focus can be aimed at this rapidly growing sector of the population. In this way the elderly could benefit from the public health emphasis on prevention and community medicine. By undertaking the Geriatric Curriculum Development Project, we are taking steps in this direction.

In this project, supported by a grant from the Public Health Service of the Department of Health and Human Services, we have made a beginning in developing several instructional products. This simulated resource book, labelled "Gerontopia", is intended for use by students wishing to enhance their knowledge and skills regarding policy and program planning for the elderly.

We intend to make Gerontopia available to others with the hope that many users outside of our own group will be able to benefit from our efforts to promote career development in the field of aging.

Harry T. Phillips, M.D., D.P.H.
Project Director

ACKNOWLEDGEMENTS

Special appreciation is in order for Bettye Clark, whose patience and persistence in typing was essential. Various individuals in the state government and at the university were also particularly helpful in assisting the first author with collecting statistical information incorporated into the book.

INTRODUCTION

Concern for the well-being of a rapidly expanding sector of the country's population, older Americans, has led to the creation of numerous programs (both governmental and non-governmental) at many levels of effort. A myriad of programs and services have come into operation, each attempting to address needs identified by the sponsoring organizations. Yet many gaps in service coverage exist, and barriers to program access may be experienced by certain subgroups of older persons (e.g. rural elderly, minorities, persons exceeding low-income requirements for services, the frail and the isolated).

With the above in mind, this resource book has been compiled for several purposes. First, it is intended to provide an overview of the people and resources in a state fictitiously named Gerontopia, including comparable national and regional data when available. Second, it is designed to serve as a tool for simulation of policy or program planning. By enabling a student to examine the conditions and needs of the older population of a state, the resource book can be used to generate ideas for policies and programs which provide alternatives to existing service strategies.

The Appendices provide supplementary information on a range of organizations which may be involved in planning and/or implementing services for older people. They also suggest sources for further statistical and funding information, plus a listing of innovative programs in existence.

Gerontopia is primarily intended to facilitate the process of experiential learning by means of a simulation exercise. It can be used as part of a larger course, or it could provide the basis of a mini-course for planning. In the real world, information relevant to the development of a policy or program plan is never laid before the proponent in a systematic way as is done in Gerontopia. However, since collection of information necessary for planning consumes a great deal of time, this resource book makes it possible for students to use the time saved on other matters.

While the "data" provided in the resource book come from national surveys and data compiled by the state government of North Carolina, the identification of the state has been disguised to allow for flexibility of use in a variety of instructional settings. The statistical and other information provided was designed only for instructional use and not for reference purposes. Citations for specific state documents used have therefore been eliminated, but are available upon request. If more information is desired regarding state-to-state variation, individuals can refer to federal legislation for more detail, since state programs are often an extension of federal programs.

PART ONE

THE SETTING AND ITS PEOPLE

Chapter I

THE SETTING

In this section, a general picture of Gerontopia will be provided in terms of climate and geography, personal income and employment, and major economic activities of the state.

Chapter I

THE SETTING

Climate and Geography

Gerontopia is located in a region of the country characterized by a humid, subtropical climate. Temperatures are relatively moderate (rarely exceeding 90°F or dipping below 10°F) throughout the year. While summers tend to be long and hot, winters are short and mild. Rainfall is sufficient to support agricultural growth throughout the state (State Atlas).

The state can be divided into four fairly distinct geographical zones on the basis of soil composition, vegetation, height above sea level, etc. These four regions are commonly referred to in the following terms: Tidewater, Coastal Plain, Piedmont, and Mountain. The climatic and geographical diversity of the state has made it popular for recreation. In fact, 13% of the state's total area of 48,880 square miles consists of recreational land.

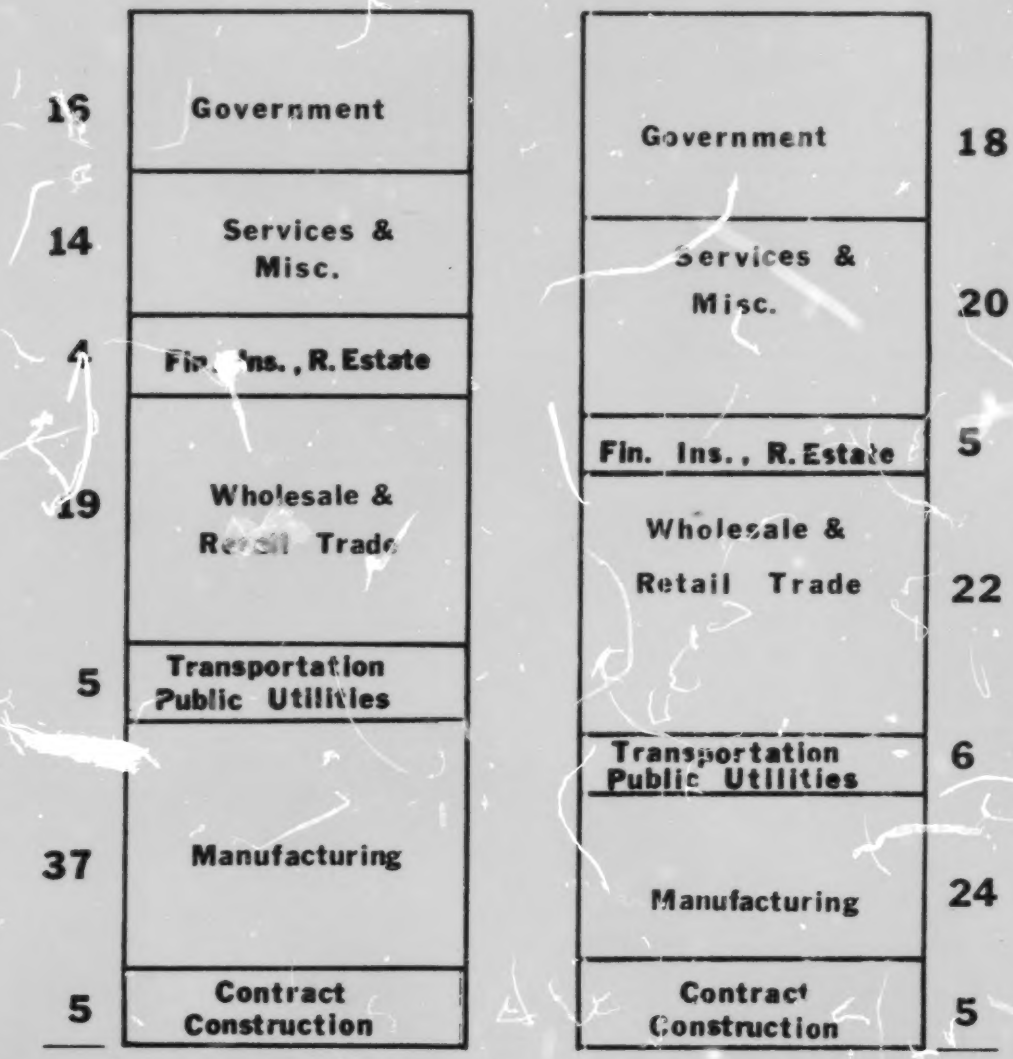
Personal Income and Employment

Over the past several decades, the percentage of persons employed in agriculture dropped dramatically, from 25.9% in 1960 to 5.0% in 1977. This decrease is accounted for primarily by growth in non-manufacturing employment (60.2% of employment) especially in terms of government and service jobs. However, Gerontopia still has a relatively high rate of employment in manufacturing (34.8%) compared with the country as a whole (23.0%). Figure I-A demonstrates differences in employment in non-agricultural establishments when Gerontopia is compared with national estimates.

In 1977, Gerontopia's per capita personal income was $5,916, lower than the national average of $7,026 for that year. Real personal income in Gerontopia is rising at a higher rate than in the nation as a whole. This trend is primarily due to the following factors: a sharp drop in low-wage agricultural employment, rapid expansion of the industrial and service sectors, and higher participation rates in the labor force by the adult population. The state's industries have tended to be labor-intensive rather than wage-intensive, which depresses the rise in wages. However, the number of capital-intensive industries, which employ more highly-skilled workers, have been steadily growing in the state, and this may lead to continued strengthening of personal income (State Atlas).

Figure I-A

PERCENT OF NONFARM EMPLOYMENT IN ALL NONAGRICULTURAL ESTABLISHMENTS 1977



100% = 2,128,300

82,142,000 = 100%

SOURCE: State Department of Commerce, Employment Security Commission, in cooperation with U. S. Bureau of Labor Statistics.

Wage rates in Gerontopia are among the lowest in the nation. In 1973, the wage rate was only 73.4% of the national average. The gap in earnings is greatest for low wage workers in rural areas. In 1974, only 6.9% of Gerontopia's workers were in unions, compared with the national average of 26.2%, distinguishing Gerontopia as the least unionized state in the country (Statistical Abstract, 1979).

Agriculture

Gerontopia leads the nation in sales of tobacco and sweet potatoes. Extensive sales in poultry place the state among the top five in this area (State Atlas). While farms in Gerontopia tend to be smaller than the national average, farms are increasing in size while decreasing in number across the state (See Figure I-B).

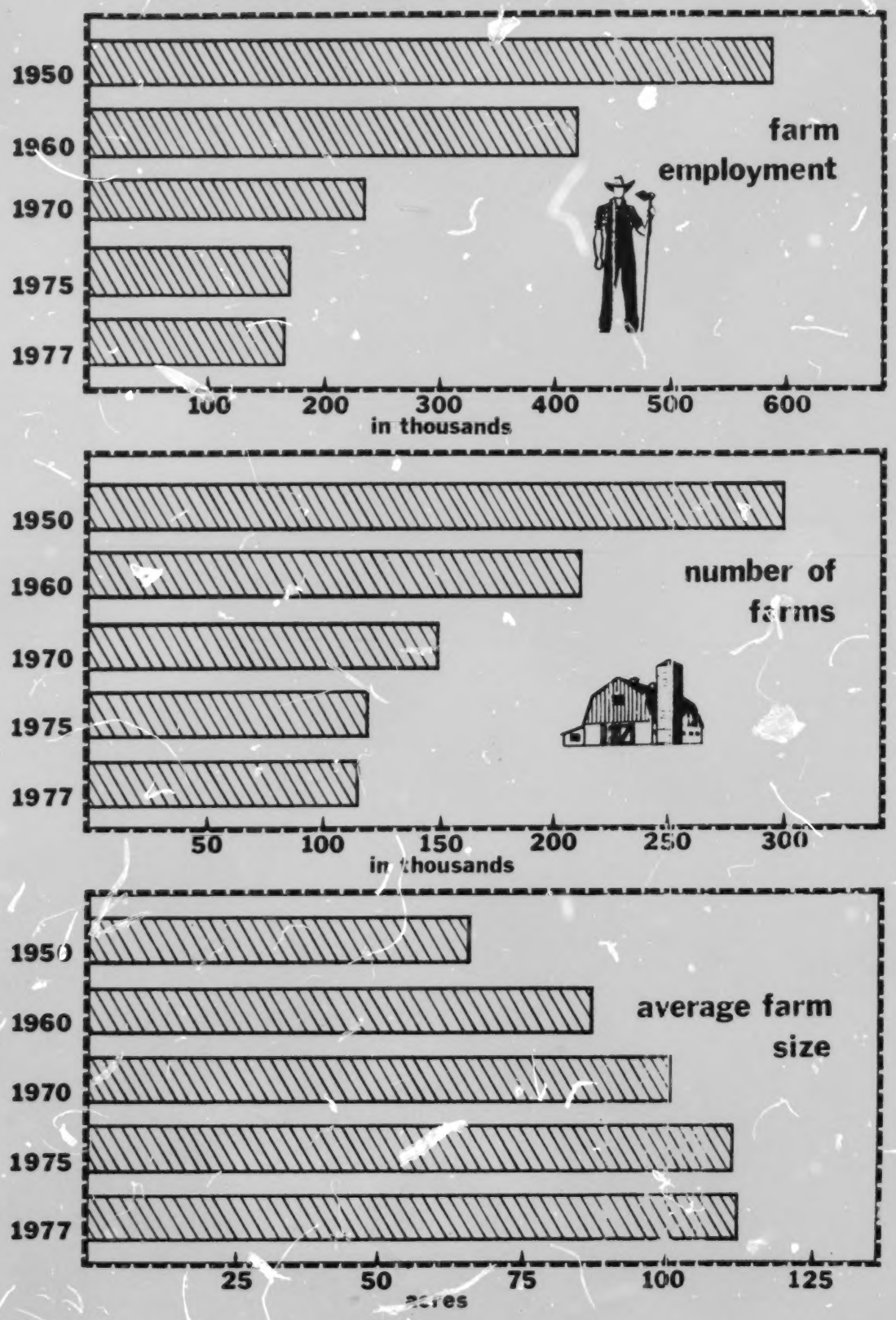
Manufacturing

Employment in manufacturing provides the primary source of personal income in the state. Gerontopia is one of the leading manufacturing states in the country. The state is first in tobacco-related manufacturing, and ranks high in the textile and furniture-making industries. Paradoxically, expanded industrialization has not been paced with high levels of urbanization. Manufacturing activity tends to be dispersed throughout the state (State Atlas).

Figure I-E

GERONTOPIA FARM TRENDS

1950, 1960, 1970, 1975, 1977



SOURCE: [redacted] Department of Agriculture, Crop & Livestock Reporting Service.

Chapter II
STATE GOVERNMENT ORGANIZATION AND PLANNING

An overview of the state's organizational structure is presented, with an emphasis on the activities of the Department of Human Resources (DHR). Program planning within DHR is described, and information on state budgeting is noted.

Chapter II.

STATE GOVERNMENT ORGANIZATION AND PLANNING

The executive branch of state government consists of the Office of the Governor, Office of the Lieutenant Governor, and seventeen major Departments (See Figure II-A). Among his duties and powers as chief executive of the state, the Governor has final authority over all expenditures of the state, and is responsible for the administration of all funds and loans from the federal government. He has the power to reorganize and consolidate state agencies, and to make appointments to more than 300 statutory bodies and 45 non-statutory advisory groups. Though he does not have the power to veto, he does influence the law-making process by his legislative and budgetary messages to the legislature. By recent amendment to state law, the Governor now has the ability to succeed himself in his four-year term of office (State Government Manual).

The primary responsibility of the Lieutenant Governor is to preside over the Senate.

The chief administrators, or Secretaries, of each of the seventeen departments are responsible to the Governor. Some of the administrators hold positions by appointment from the Governor, while others are elected to office (State Government Manual).

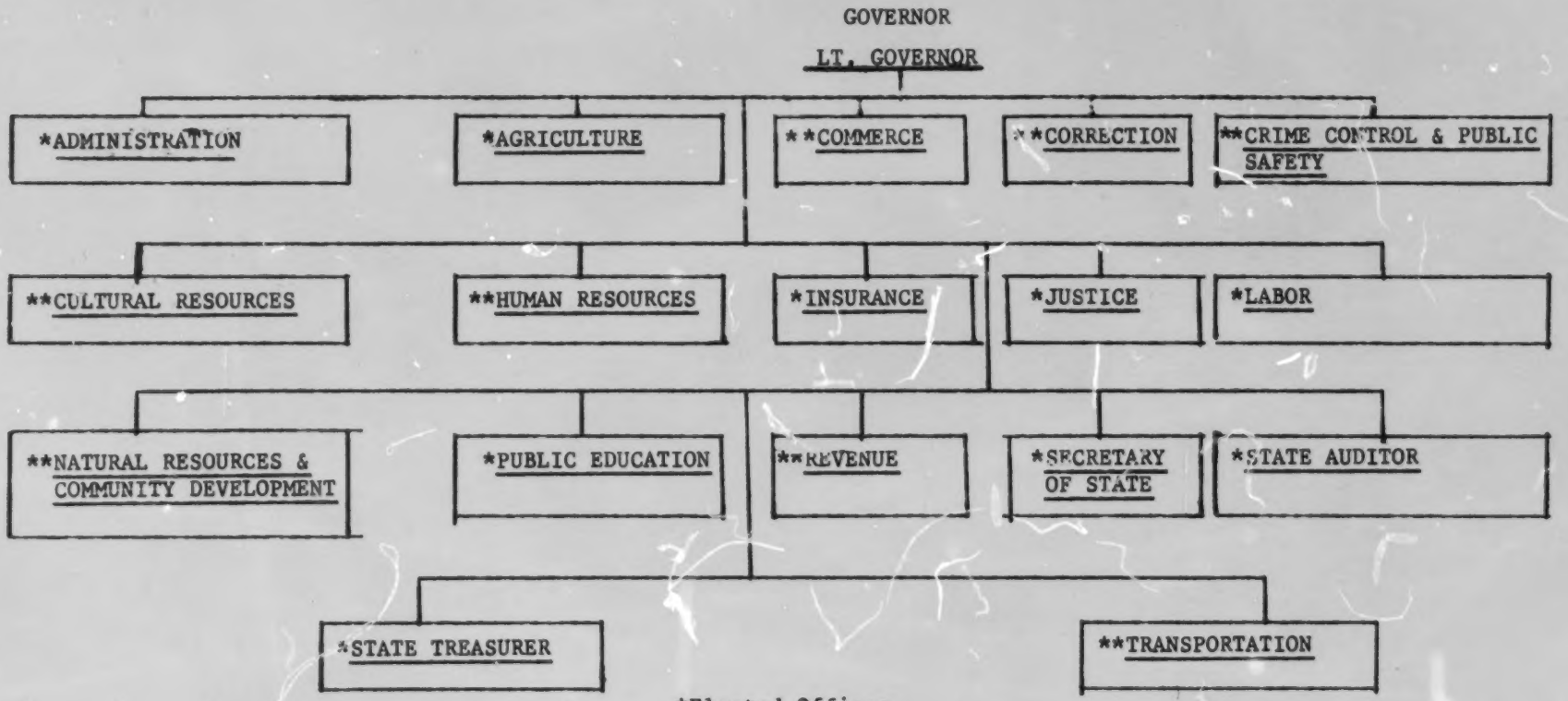
The Department of Human Resources

Of the seventeen major departments, the Department of Human Resources (DHR) is most concerned with services to the elderly. DHR is the largest department in state government, with approximately 18,000 employees. The annual budget is almost one billion dollars, with the greatest percentage of funds coming from the federal government, and the remainder from state, county and other sources.

The principal administrator of DHR, the Secretary, is appointed by the Governor. In addition, Assistant Secretaries have been appointed in the areas of child health and aging, two areas in which the Department has established service priorities (DHR Annual Plan of Work).

The Board of Human Resources, chaired by the Secretary and composed of six members from the several divisions of the Department and eight members-at-large, all appointed by the Governor, acts as an advisory body to the Secretary on human services programs.

Figure II-A. State Divisions



*Elected Offices
**By Appointment

The services of DHR are provided through a number of programs (See Figure II-B) which are organized within the following DHR divisions and agencies:

Divisions

Plans and Operations	Budget and Analysis
Personnel Services	Blind Services
Health Services	Social Services
Medical Assistance	Vocational Rehabilitation Services
Youth Services	Aging Services
Mental Health, Mental Retardation, and Substance Abuse Services	

Agencies

Volunteer Services	Governor Morehead School
Public Information	Schools for the Deaf
Information and Referral	Confederate Women's Home

Following is a description of divisions which are particularly relevant to the older population of the state:

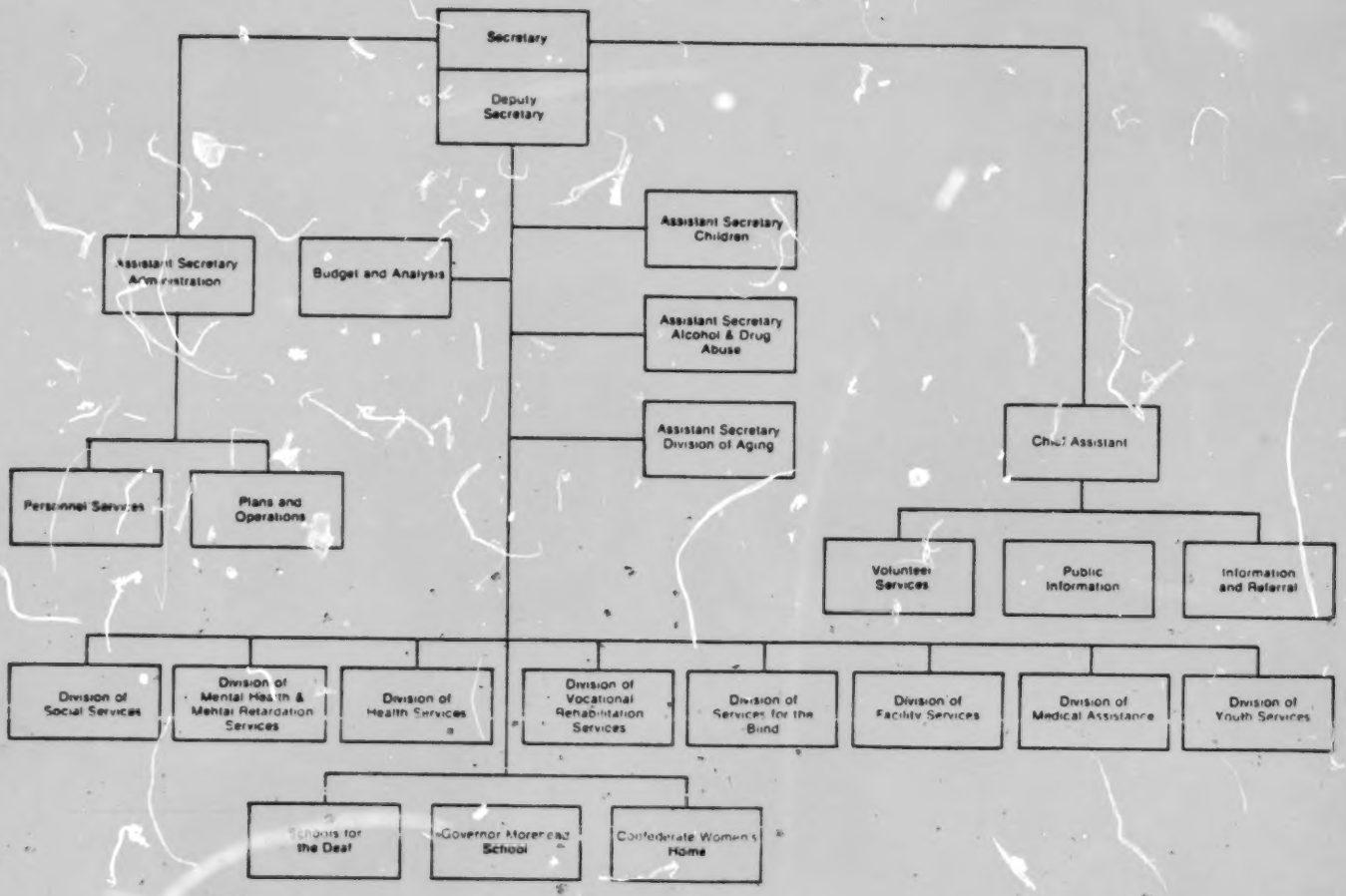
Division of Aging (DoA)

In 1965 the Gerontopia General Assembly created the Governor's Council on Aging, and designated it the State Agency on Aging, in accordance with a mandate under the Older American's Act (OAA). The Council was created as a coordinating and information center to plan, communicate, and be the advocate agency for developing service programs to meet the needs of older Gerontopians. In 1972, when the Department of Human Resources was created as part of state government reorganization, the Coordinating Council was placed under the authority of the Secretary of DHR. Soon its main function became the administration of federal funds under the OAA. In 1973, when amendments to the OAA called for planning for comprehensive delivery systems for services on an areawide basis, the DHR was designated as the sole agency to 1) develop and administer the State Plan on Aging; 2) coordinate all state activities related to the purpose of the OAA; 3) divide the State into distinct planning and service areas; 4) designate Area Agencies on Aging for each planning and service area for which a plan was to be developed; 5) approve area plans developed by such Area Agencies; 6) monitor and assess the implementation of each area plan; and 7) carry out all other functions and responsibilities as prescribed under the plan of the State Agency. The Coordinating Council was designated as the organizational unit within the State Agency with delegated authority for development of the State Plan.

In 1975, the name of the Coordinating Council was changed to the Office for Aging, and in 1977, the agency was elevated to Division status. Its principal responsibilities today are statewide planning, coordination, administration, and evaluation of programs and activities related to the purposes of the Older Americans Act, including all the provisions designated to the State Agency (DoA Description of Services).

Figure II-B

DEPARTMENT OF HUMAN RESOURCES



Programs administered by the Division of Aging include employment, advocacy (Nursing Home Ombudsman Program and Legal Services Development Program), senior centers, and social services (See Chapter VII). The goal of the DoA is to improve the quality of life for older Gerontopians by serving as their advocate and by promoting a comprehensive coordinated service system through administration of the Older Americans Act program. The DoA works to secure and maintain maximum economic and personal independence and dignity for older persons (in particular, through the Area Agencies' contracts to local providers) by providing supportive services and removing individual and social barriers to their independence (DoA Description of Services).

Division of Social Services (DSS)

The goal of DSS is to insure that all those in the state who meet prescribed eligibility criteria receive the quality assistance and services to which they are entitled, in order that, whenever possible, they may gain or maintain self-reliance.

Gerontopia has a state-supervised/county-administered social services system. The DSS supervises the administration of the Aid to Families with Dependent Children public assistance program and the State/County General Assistance Program administered by the 100 county departments of social services. It also supervises the administration of the food stamp program and social services programs (under Title XX) administered by the county departments. Certain state-level programs are actually administered by the DSS. Officers include the Director and an eleven member Social Services Commission appointed by the Governor, which has the authority to adopt, amend, and rescind rules and regulations necessary for proper administration of the program. Funding of DSS programs is largely federal, with the remainder being state and county (DHR Description of Services).

Division of Health Services (DHS)

The purpose of the Division of Health Services is to serve the public health needs of the people of Gerontopia. The DHS supervises the county and district health departments, which administer local public health programs. In addition to operating several hospitals, DHS provides consultation to other government agencies, voluntary agencies, professional societies and civic groups. The DHS officers include a Director and a twelve member Commission of Health Services (five members are appointed by the Medical Society of Gerontopia and seven members are appointed by the Governor). The Commission's responsibilities are to approve rules and regulations and adopt standards. The DHS is comprised of seven sections: Epidemiology, Laboratory, Administrative Services, Dental Health, Sanitary Engineering, State Medical Examiner, and Personal Health. Each of these section is divided into Branches. For example, Personal Health is divided into Chronic Disease Branch, Developmental Disabilities Branch, Family Planning Branch, Maternal and Child Health Branch, and Nutrition and Dietary Services Branch. The Home Health Services Program (See Chapter VIII) is supervised by the Chronic Disease Branch (DHR Description of Services).

Division of Mental Health and Mental Retardation Services

This Division provides state-wide services to the mentally ill, the mentally retarded and the alcohol or drug abuser through a system of state-operated institutions and locally operated mental health programs. Residential care and treatment are offered at four regional psychiatric hospitals, four mental retardation centers, three alcohol rehabilitation centers, and a re-education program for emotionally and disturbed children. Deinstitutionalization and community care are major emphases. Community services are offered at the 41 area mental health programs, with services including outpatient care, day treatment, emergency services, local inpatient hospitalization, and consultation and education. One day-treatment center for the elderly has so far been established in the state. Other locally administered programs include halfway houses, sheltered workshops, and activity programs. Officers include a director, deputy directors, and a fifteen member regulatory Commission appointed by the Governor (DHR Description of Services).

Division of Facility Services

This Division is composed of four major sections: Licensure and Certification, Construction, Emergency Medical Services and Rural Health Services. The Licensure and Certification Section licenses health and social service institutions, and includes in-depth surveys of hospitals, nursing homes, and home health agencies. Group homes are licensed in cooperation with the Division of Social Services and local departments of social services. The Construction Section insures that health and social services facilities are safe and functional, providing consultation to facility owners and architects involved in planning, building, remodeling or construction under the Health Care Facilities Finance Act. The Office of Emergency Medical Services is involved in improving emergency medical care throughout the state. The primary goal of the Office of Rural Health Services is the establishment of rural health centers in medically deprived areas of the state.

The Division's goals include 1) coordinating facility regulation and development with service-delivery programs in the Department of Human Resources, 2) working with the Division on Aging in the implementation of the Patients' Rights Bill, 3) ensuring a coordinated program with the Division on Aging's federally funded Nursing Home Ombudsman Program, and 4) ensuring a coordinated program with the State Health Planning and Development Agency (SHPDA) in the area of health planning (See below). (DHR Description of Services)

Division of Medical Assistance

This Division has responsibility for administering the state's Medicaid program, including policy making, eligibility determination systems, financial analysis and contract procurement and monitoring. Individual eligibility for Medicaid assistance is determined by the 100 county social services departments. Medicaid services are financed by federal state, and county funds, and are rendered by medical care providers across the state, such as physicians, hospitals, mental health centers, and nursing homes. The Director is the principal officer of the Division.

Under DHR's organization, the state has been divided into four regions, with Regional Offices which serve as an extension of DHR's management. At the Regional Office are State personnel representing each of the service divisions of DHR, except Aging and Medical Assistance. The main task of these Regional Offices is to provide technical assistance to counties and the 18 Councils of Government (COGs), comprised of clusters of local governments (discussed below).

Divisions within DHR maintain some degree of autonomy, as exemplified by their regional organization, which are not always coterminous with DHR's or with each other's. Each Division formulates its own plans of operations which it submits to DHR (DHR Annual Plan of Work).

Most of the human services in Gerontopia are actually delivered by local human service agencies, such as health departments, county social services and mental health centers. Other services are delivered directly by the state through field staff and institutions located throughout the state (DHR Description of Services).

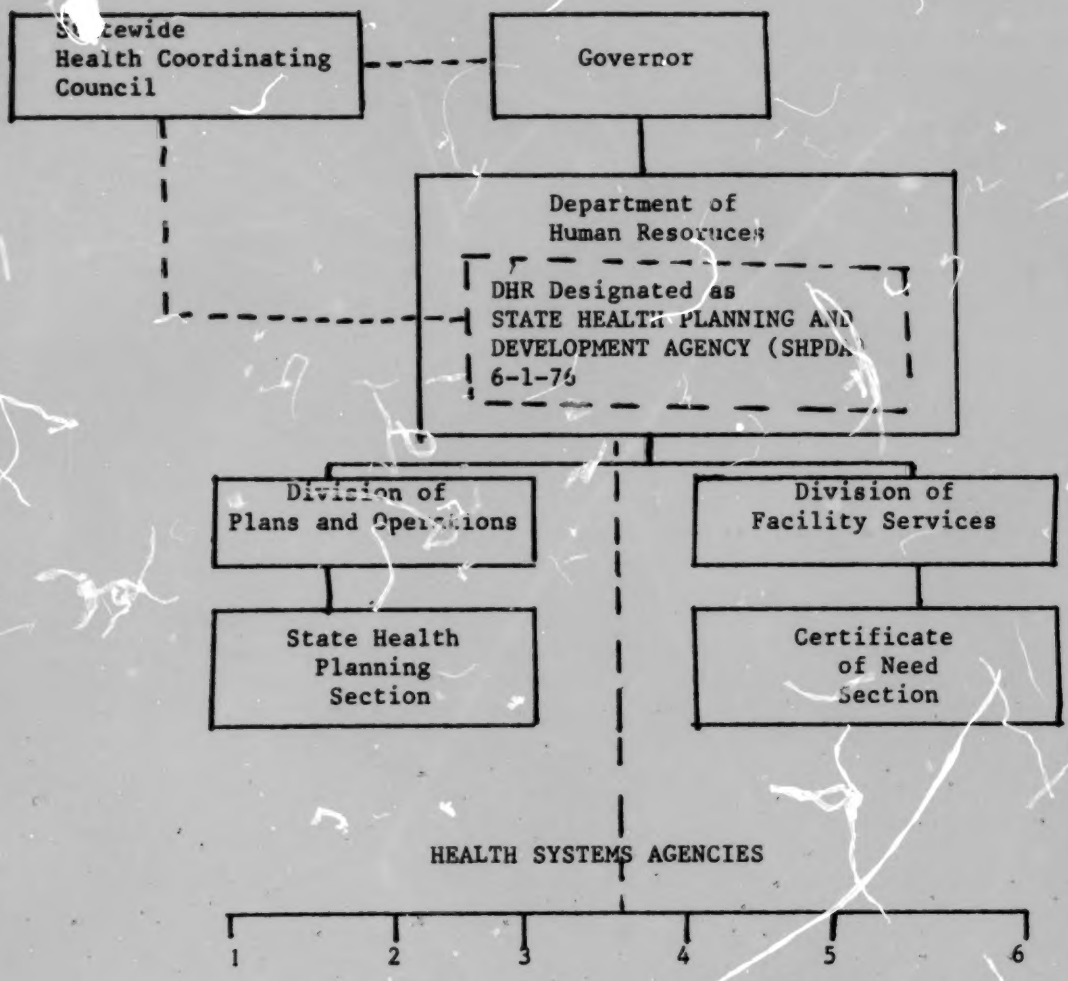
Planning within DHR

In 1971, in response to a federal requirement that all local governments using federal funds conform to a master plan of development for a region, the Governor divided the 100 counties of the state into 17 multipurpose planning regions, identified by the letters A through R. (There are now 18 planning regions, due to the subsequent subdivision of region G into two regions). In each of the planning regions, the Lead Regional Organization, also known as a Council of Governments (COG), gives assistance to local governments, coordinates services, assesses the needs of its regions, and functions as a liaison between state and county departments. A Council of Governments is composed of representatives of counties and major municipalities within each of the 18 regions. There is an Area Agency on Aging located in each of the 18 COG's which performs a somewhat similar function with respect to aging services, though funded under federal legislation, and not a part of state government (State Guide to Law and the Elderly).

The enactment of the National Health Planning and Resources Development Act of 1974 (PL 93-64), which called for a national health planning system, led to the establishment of 205 health services areas throughout the United States, each served by a Health Systems Agency (HSA). These HSAs, though not involved in the actual delivery of services, have the power to review, approve or disapprove applications for some federal funds, and review and make recommendations on other proposed expenditures (State Health Plan). They are also responsible for preparing and implementing plans for health service delivery. In Gerontopia, there are six multicounty regions designated as HSAs. These HSAs are private, non-profit organizations which develop Health System Plans (HSPs) for their regions. Based on the findings and conclusions presented in these HSPs as well as on existing state-level plans and programs, the State Health Plan is developed by the forty-member Statewide Health Coordinating Council (SHCC). The State Health Planning and Development Agency (SHPDA) is responsible for assisting the SHCC in conducting the

Figure II-C

CHART OF AGENCIES INVOLVED IN STATE HEALTH PLANNING



state health planning and resource development activities. The Department of Human Resources has been designated by the governor as the SHPDA. Specifically, the DHR, through staff designated as SHPDA staff, is responsible for developing the Preliminary State Health Plan, which is then submitted to the SHCC for consideration as the State Health Plan (See Figure II-C). It also administers the state's certificate-of-need law (State Health Plan).

In the 1979 amendments to the National Health Planning and Resources Development Act (PL 96-79), HSA's are required to coordinate their planning with mental health and aging agencies.

The State Budget

Table II-1 shows the total state budget authorized for FY 1979 according to funds from the following sources: the general fund, the highway fund, federal funds and other sources. The total state budget has more than tripled over the course of a decade, from $1.3 billion in FY 1969 to $4.4 billion in FY 1979. The largest portion of state funding (approximately 58% of the total budget) comes from the general fund, and this amount has remained constant over the past ten years. Federal funds increased from 17% of the budget in FY 1969 to 24% in FY 1979. These funds primarily support education, social services, highway construction, natural resources, and community development. Allocations for public schools (30.5%), human resources (23%), higher education (13.4%) and transportation (12.6%) comprised over three-fourths of the total authorized budget in FY 1979.

The State Office of Budget and Management reviews requests for funds which are submitted by each department, according to the priorities established by the departments. Recommendations made by Budget and Management are then forwarded to the Governor and the Advisory Budget Commission. Public hearings are held to enable department representatives to appear before the Advisory Budget Commission. The Commission and the Governor take into account needs expressed by all of the departments when proposing budgets for each fiscal year.

Table II-1

TOTAL STATE BUDGET, 1978-79 AUTHORIZED

Function	General Fund	Highway Fund	Other	Federal	Total Net
General Assembly	$ 7,452,462	$ –	$ 116,005	$ –	$ 7,568,467
Judicial	63,464,251	–	–	–	63,464,251
General Government	74,067,157	1,719,662	4,027,036	2,555,175	82,369,030
Public Safety and Regulation	23,835,222	30,421,149	4,975,194	58,447,548	117,679,113
Correction	94,119,629	500,000	2,062,873	–	96,682,502
Education:					
Public Schools	1,094,467,550	–	14,552,336	194,727,204	1,303,747,090
Community Colleges	139,335,006	115,556	13,879,259	7,592,847	160,922,678
Higher Education	380,483,142	–	168,176,119	21,525,370	570,184,630
Cultural Resources	14,006,822	–	371,809	1,395,011	15,773,642
Subtotal Education	1,630,337,520	115,556	196,979,523	225,240,432	2,052,673,041
Transportation	2,626,571	367,179,244	480,966	171,560,375	541,847,156
Human Resources	388,830,527	53,894	100,242,539	495,088,044	984,215,004
Natural Resources and Community Development	24,539,081	–	12,140,544	86,563,197	123,242,822
Agriculture	16,996,237	1,163,317	6,661,343	1,494,201	26,315,098
Debt Service	53,000,000	29,691,000	–	–	82,691,000
Reserves and Transfers	74,643,128	29,459,597	–	–	104,102,725
Subtotal Operating	$2,451,866,785	$460,303,429	$327,686,023	$1,040,948,972	$4,280,805,209
Capital Improvements	126,008,818	1,533,995	780,000	1,744,537	130,067,350
Total	$2,577,875,603	$461,837,424	$328,466,023	$1,042,693,509	$4,410,872,559

Source: State Summary of Appropriations

Chapter III

DEMOGRAPHIC PROFILE

Gerontopia's population distribution is first described in terms of age, region and urban/rural residence. Patterns of migration are also noted. Next, the older population of the state is discussed in terms of race, marital status, and education. National comparisons are provided where available.

Chapter III

DEMOGRAPHIC PROFILE

Population

According to 1970 Census figures, Gerontopia was the 12th most populous state in the country. More recent estimates (1976) rank the state 11th in total population, 14th in actual numbers of persons over age 65, but 37th in proportion of the population age 65 and older (State Atlas of the Elderly).

Over half (53%) of the state's residents live in the Piedmont area of the state, according to the 1970 Census. The Coastal Plains account for 22.9% of the population, and the Mountain and Tidewater regions account for 15.0% and 9.1% of the state's residents, respectively, (State Atlas). Table III-1 shows population counts and percent change for each Health Systems Area for the years 1940, 1950, 1960, 1970, and 1977.

Gerontopia's older population is increasing at a rapid rate. In 1960, there were 312,167 persons 65 years of age and older, comprising 6.85% of the state's population. If persons age 60-65 are included as well, this group represented 10% of the population in 1960. By 1970, the age 65+ group comprised 8.11% of the state's population; 1980 and 1990 projections are 10.12% and 11.85% respectively. The 1990 figure represents an estimated 763,000 persons. If those age 60-65 are included, Gerontopia's elderly population may surpass one million by 1990. The age 75+ group is one of the fastest growing segments in the state; representing 2.23% in 1960, the proportion is expected to more than double at 4.65% in 1990 (roughly 300,000 persons) (State Office of Budget and Management).

Gerontopia's highest concentration (over 14%) of its elderly population lives in five counties in the Mountain region. The second largest cluster of persons 65 and older live in the northern and central Tidewater area, and a third, more diffuse cluster of older persons reside in the South-Central Piedmont. Five of six counties with a relatively large older population compared to younger age groups contain retirement and resort communities (State Atlas of the Elderly).

Table III-2 shows the distribution of the state's population age 60 or older by Health Systems Area.

Table III-1.

GERONTOPIA POPULATION COUNT AND PERCENT CHANGE BY HEALTH SYSTEMS AGENCY (HSA): 1960, 1970, 1977

	1960	1970	% change 1960-70	1977	% change 1970-77
HSA I	779,500	867,642	11.3%	946,300	9.1%
HSA II	862,204	981,393	13.8%	1,045,600	6.5%
HSA III	727,022	870,150	19.7%	930,400	6.9%
HSA IV	580,242	674,596	16.3%	757,500	12.3%
HSA V	682,995	755,344	10.6%	838,300	11.0%
HSA VI	924,192	932,934	1.0%	1,007,100	7.9%
State Total	4,556,155	5,082,059	11.5%	5,525,200	8.7%

Source: State Statistical Abstract.

Table III-2.

POPULATION AGE 60 AND OLDER IN GERONTOPIA, BY HEALTH SYSTEMS AGENCY (HSA): 1980

	REGIONAL POPULATION	60+ POP. IN REGION (% of State Total 60+)	60+ LOW INCOME (%of State Total 60+)	60+ MINORITY (% of State Total 60+)
HSA I	981,401	165,338(20.2)	87,979(10.8)	9,913(1.2)
HSA II	1,074,610	159,879(19.5)	63,969(7.8)	27,368(3.3)
HSA III	982,251	137.512(16.8)	53,171(6.5)	20,627(2.5)
HSA IV	794,250	104,842(12.8)	43,076(5.3)	29,366(3.6)
HSA V	889,712	107,652(13.2)	58,752(7.2)	33,180(4.1)
HSA VI	916,661	143,116(17.5)	78,171(9.5)	46,643(5.7)
	5,638,885	818,339(100.0)	385,438(47.1)	166,941(20.4)

Source: Division on Aging, Operations Directory.

Urban/rural distribution

Gerontopia is one of the few states in the country that has always been primarily rural (State Atlas). Table III-3 show national and regional comparisons with Gerontopia in terms of the metropolitian/ nonmetropolitan population distribution in 1975.

As noted in Figure III-A, an increasingly larger percentage of the population lives in urban areas (33.7% in 1950, 39.5% in 1960, 45.0% in 1970), and the proportion of urban residents* is expected to exceed the rural percentage in the 1980's. Residents of the state are increasingly moving from rural farms to rural non-farm areas and larger metropolitan areas. By 1970, roughly nine of every ten rural residents lived in non-farm rural environments (State Atlas).

Among Gerontopia's four geographical regions, the Piedmont area contains the largest percentage of the state's total urban (63.7%) and total rural (44.2%) population. In almost half (49) of the state's 100 counties in 1970, no more than 25% of the county population lived in urban areas. Thirty-four counties had no urban residents; these counties were located primarily in the Mountain and Tidewater regions (State Atlas). Older residents of Gerontopia's counties are about as urban or more urban than county residents as a whole (State Atlas of the Elderly).

Migration

In the decades before 1960, Gerontopia's total population count was lowered by greater out-migration than in-migration, although in recent decades this trend appears to be decelerating. Black persons (especially females) have been more likely to move out, while migration into the state was largely accounted for by young white males. The latter is due in part to the existence of several military installations in the state. All groups above age 55 (except black women) increased through migration, which may reflect Gerontopia's appeal as a retirement area. In looking at patterns of migration between 1975 and 1979, persons under 65 in Gerontopia were much more likely to be living in a different place (41.7%) at the end of that period than were older persons (12.1%). Roughly half of the migration for either the younger or the older group involved moving to another residence within the same county (U.S. Bureau of the Census, 1979).

Age, Race, Marital Status, and Education

Age

While the younger age groups comprise a large percentage of the state's population (just over 40% of residents were 20 years of age or younger in 1970), the over-65 group is the fastest growing group in the state (State Atlas). Both of these facts are consistent with the national trends.

*Urban is defined as any area with 2,500 or more inhabitants.

Table III-3.

METROPOLITAN/NON-METROPOLITAN POPULATION DISTRIBUTION:
U.S., Multi-state Region, and Gerontopia, 1976.

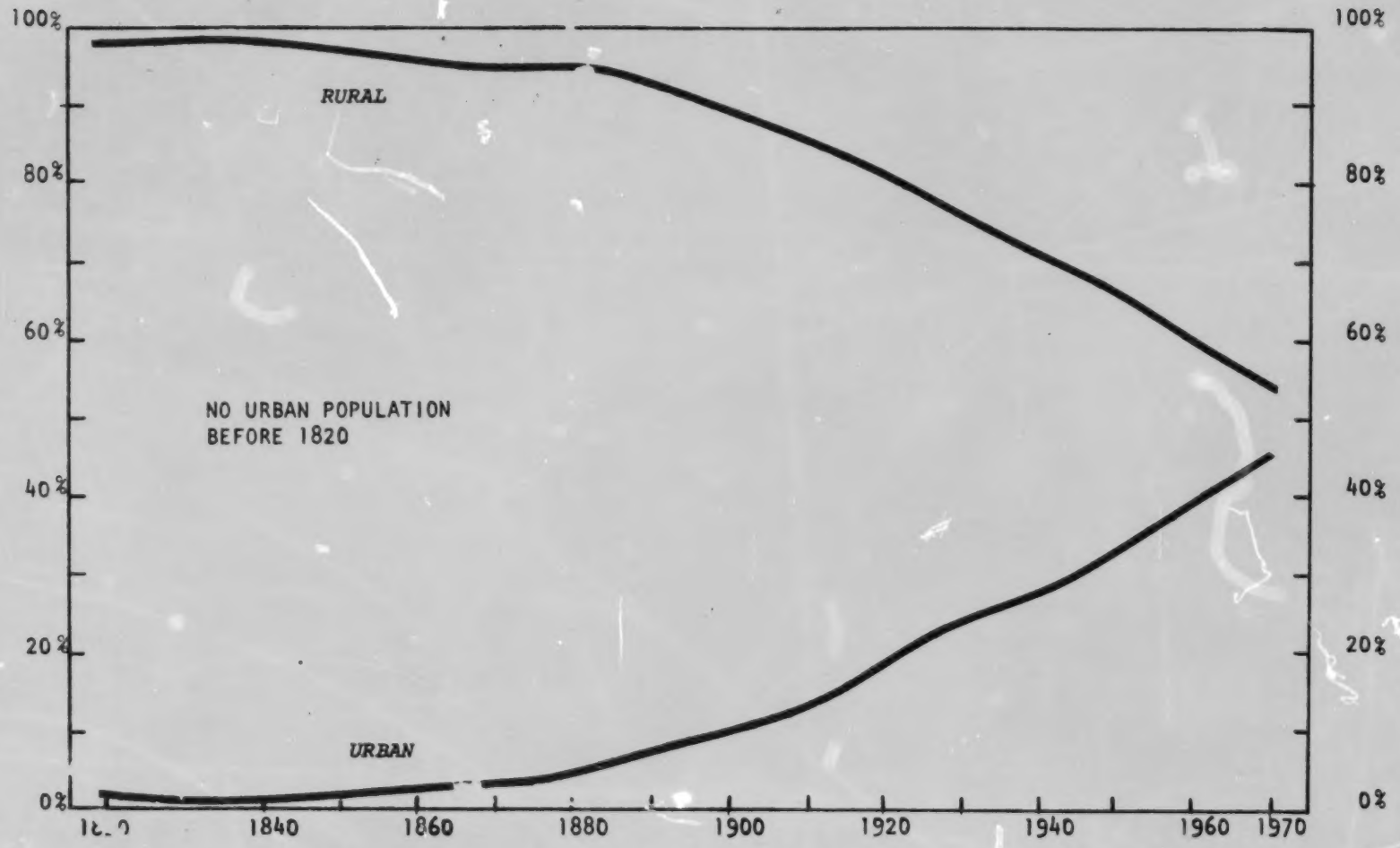
	U.S.	Multi-state Region	Gerontopia	Number of States Higher
Metropolitan Pop. (millions)	155.0	22.1	2.5	20
Percent of Total	72.8%	65.4%	45.1%	33
Non-metropolitan Pop. (millions)	58.0	11.6	3.0	0
Percent of Total	27.2%	34.4%	54.9%	16

Source: State Department of Public Health.

Figure III-A.

GERONTOPIA

POPULATION BY RESIDENCE, 1820 TO 1970



Source: State University Report

Race

As shown in Figure III-B, the white population accounts for an increasingly large percent of the state's population growth (14.5% from 1960-1970) compared to growth in the non-white population (2.8%). This is in contrast to the national trend of greater population increase among the non-white rather than the white population. In terms of regional distribution according to race, the Mountain area is primarily white (94%), while the Coastal Plain has the lowest proportion of whites (62.6%). The Piedmont and Tidewater areas are closer to the State average white population of 76.8% (State Atlas).

The black elderly comprise 19.3% of Gerontopia's older population which is slightly lower than the figure for the State's total black population of 23.2%. Almost all of the counties with an elderly population at least one-third black are found in the eastern half of the state, which reflects the heavy involvement of blacks in the agricultural section of the Coastal Plain (State Atlas of the Elderly).

Marital Status

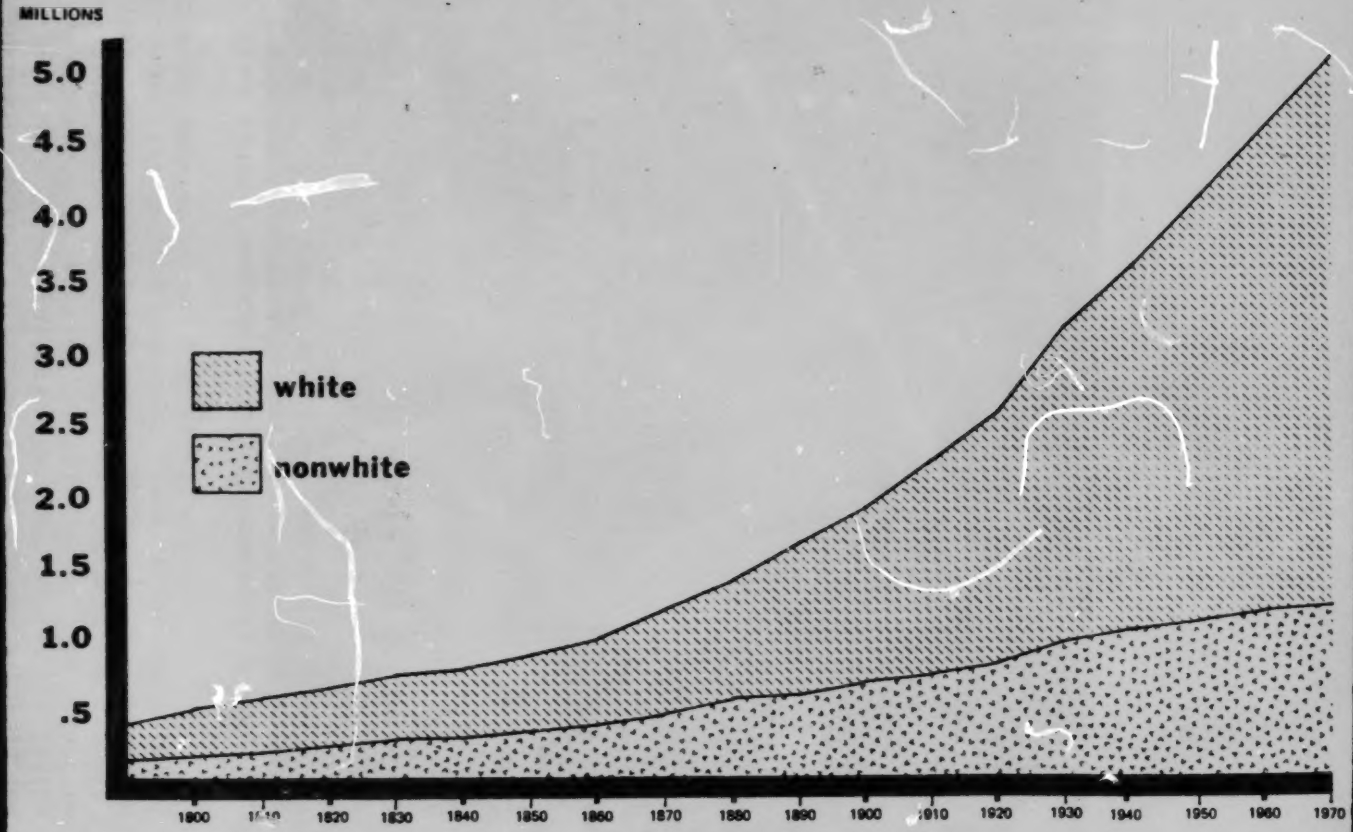
Among persons age 65 and older in the United States, women are less likely than men to be married. This trend is more pronounced for non-white persons; an estimated 77.0% of white men over age 65 were married compared to 60.5% of the non-white males, and 38.5% of elderly white females were reportedly married compared to 27.2% of the non-white women (U.S. Census Bureau, 1979). These differences are primarily due to earlier age of death for men compared to women and for minorities compared to the white population.

Education

While the percentage of older men and women in Gerontopia with no formal schooling (2.2%) is similar to the national average (2.6%), elderly males in Gerontopia were less likely to have completed high school or to finish education beyond the high school level than older men in the nation as a whole. The latter trend is more marked for elderly white males than for older non-white men.

Figure III-B.

Population Trends in Gerontopia by Race, Years 1800-1970



	PERCENT INCREASE																
White	17.2	11.4	11.4	12.8	2.5	14.1	13.9	17.9	16.7	21.7	19.7	18.7	18.9	25.3	14.9	16.2	14.0	14.5
Nonwhite	33.0	27.6	22.6	20.7	1.4	17.6	14.8	20.9	21.5	5.6	12.0	12.0	9.9	20.6	7.3	7.5	7.2	2.9
TOTAL	21.4	16.2	15.0	15.5	2.1	15.3	14.2	19.0	18.5	15.6	17.1	16.5	16.0	23.9	12.7	13.7	12.2	11.5

SOURCE. U. S. Department of Commerce, Bureau of the Census.
Division of State Budget and Management, Research and Planning Services.

Chapter IV

NEEDS OF OLDER PERSONS

Key determinants of the life situation for elderly people, the foundations of well-being, are multiple and interdependent. They may include income; employment; housing; health (physical, mental, social); and social supports, family and community linkages. Following is a brief discussion of each of these components of "need" for the elderly populations of the U.S. and Gerontopia.

Chapter IV

NEEDS OF OLDER PERSONS

Income

Having an adequate income is a key determinant of well-being. Income influences the adequacy of such basic needs as housing, food, health and social services, and transportation, for example. Because income is so interrelated with one's ability to meet these most basic needs, it is said to be the single most influential predictor affecting health status (NCoA, 1978). Poverty is a major factor contributing to the special vulnerability of the elderly in their desire to maintain their self-respect and dignity.

There is generally a sharp decline in the income of both families and single persons as age increases past the age of sixty-five. In 1975, families headed by a person over 65 in the United States had a median income of $8,057 compared with a median income of $14,698 for younger families (NCoA, 1978).

Though the percentage of both families and unrelated individuals below the poverty level is declining, the percentage of those unrelated individuals 65 and over below the poverty level is higher than the younger groups. In 1975, 31% of unrelated individuals 65 and over were below the poverty level compared to 21.1% of the total population (NCoA, 1978).

Certain groups within the elderly population tend to be more economically disadvantaged than others. For example, elderly blacks have incomes that are approximately two-thirds that of elderly whites, and single elderly women tend to have about half the median income of single elderly males (NCoA, 1978).

Sources of Income

By far the most common source of income for the elderly is Social Security. This is followed by income from assets, earnings, private and Government employee pensions, Veteran's pensions, and Supplemental Security Income (SSI). A very small portion of the elderly receive income from sources other than these.

When each source of income is examined to determine the extent to which each contributes to the total income, Social Security is found generally to contribute the most, followed by earnings. The extent to which other sources contribute varies with the individual's pension plans, assets, and income employment (NCoA, 1978).

Approximately half of the elderly in the state of Gerontopia are below the poverty level (State Plan on Aging). Inflationary trends increase the problems of the poverty-stricken elderly, particularly because those expenses which increase with old age, such as food, housing, medical care, and drugs, are heavily affected by inflation.

According to a NCoA recent publication, "Facts About Older Americans, 1978", only seven other states had higher percentages of the elderly living below the poverty level. None of the states ranking higher on this measure had as large an older population as Gerontopia.

Paid Employment and Retirement

Since the turn of the century the number of persons who continue to work after the age of sixty-five has declined. Mandatory retirement policies are a major contributing factor to the decline in the older populations's participation in the labor force. In 1900, two of every three males 65 and older were employed; this has decreased to less than one in five as of 1975 and is projected to be one in six by 1990 (NCoA, 1978).

The decline in employment with age has implications for the individual, who is likely to experience a sharp drop in income upon retirement as well as a greater number of years without the benefits of income from employment. Retirement may also affect other aspects of one's life such as one's self-image and opportunities for social involvement.

In 1976 approximately 20 percent of the over sixty-five male population and eight percent of the over-65 female population were in the labor force (Sourcebook on Aging, 1977). These jobs were concentrated generally in three low earnings categories: agriculture, part-time employment and self-employment. Unemployment figures are deceptively low because the 65+ population is often not considered part of the work force. For those who have been active in the work force and are counted as unemployed, length of unemployment on the average was longer than for the younger worker. Data from the National Council on Aging/ Harris survey indicates that retirement from the labor force was not the choice of two out of five older persons (NCoA, 1978).

In 1967, the Age Discrimination in Employment Act was passed in order to protect persons age 40-65 from discrimination in hiring, referral for employment, and union membership. (Some high-level executives and tenured college and university faculty may be excepted). This law was amended in 1978, and the mandatory retirement age was raised to 70 years. The impact of this change on labor force participation among older workers is currently being examined.

Housing

Housing conditions of the elderly in the United States are characterized by problems of quality and quantity. Housing needs change with age, and standards for appropriate housing go beyond bricks and mortar. Housing is related to physical and mental health status, transportation needs, economic stability and community and service linkages (Butler, 1975).

The elderly in the United States are likely to own their own homes (70%), and for most elderly a home is their only major financial asset (NCoA, 1978). The proportion of housing units owner-occupied declines somewhat among the older elderly as the units are sometimes relinquished due to circumstances attributable to financial needs or other needs which occur with the aging process.

In terms of national housing quality, the elderly generally live in more modest dwellings which may often be inferior in terms of size, facilities and overall condition. Overcrowding is not often a problem in elderly households. Maintenance of the house is often beyond the ability of the older person to manage.

According to a 1979 Needs Assessment conducted by the Department of Human Resources 26.4% of all elderly in Gerontopia experience problems with an unhealthy living environment. This includes such problems as inadequate sewerage, poor drinking water, or problems with flies, mosquitoes and rats. In the same survey, 10.6% of homes where at least one person 75 years or older resided were in substandard condition. These houses needed major repairs or were lacking one or more of the following: complete kitchen or bathroom facilities, hot and cold running water, electricity, or heat in every room.

Special types of housing are sometimes available in a community for the elderly. These may include various government subsidized public housing, congregate housing or retirement communities (See Chapter VI).

Health

The most widely accepted definition of health is that of the World Health Organization: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO, 1946). Thus, health describes the ability to function well physically, mentally, and socially.

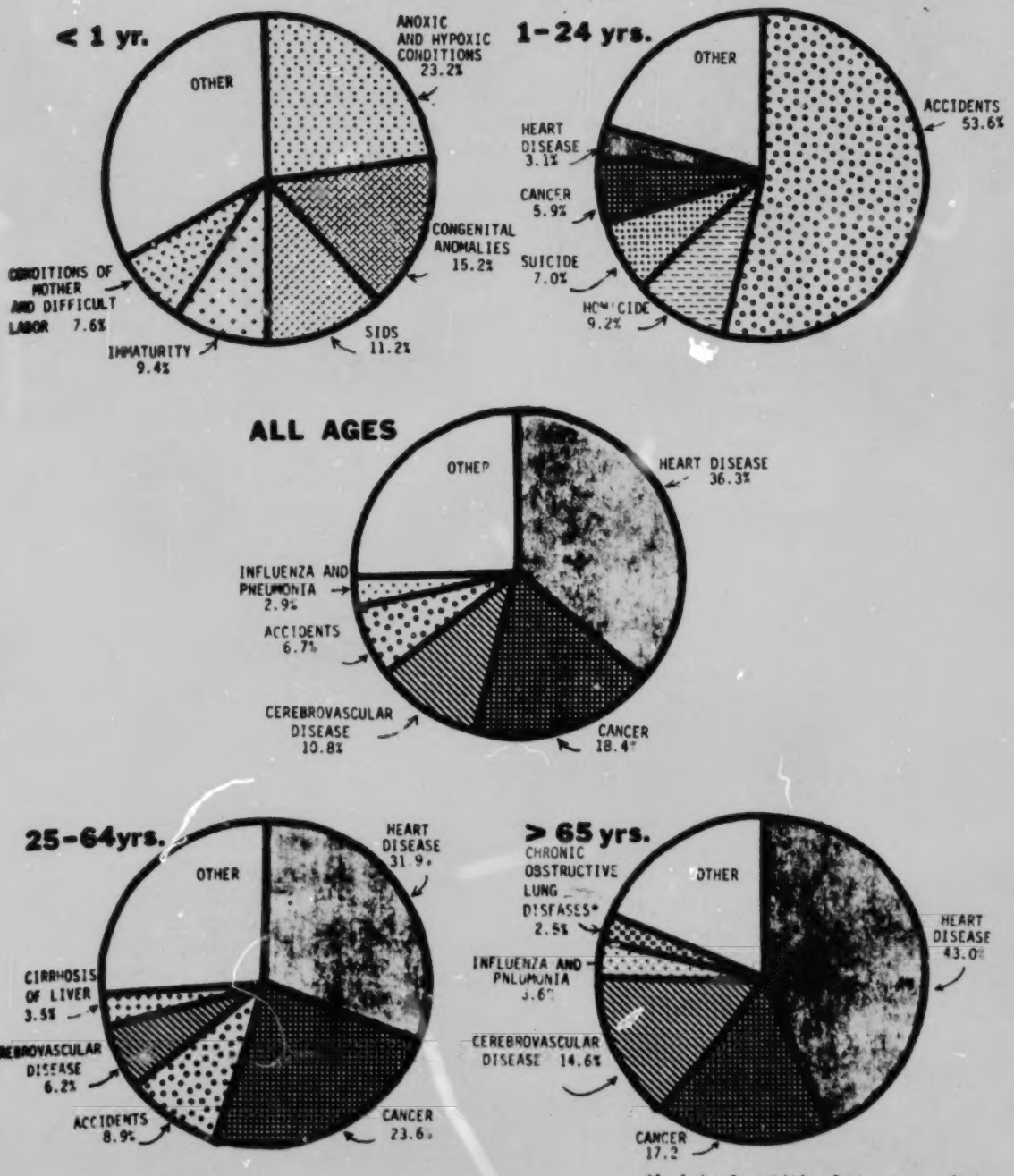
The elderly are not a homogeneous group; there is a great variability in their health status, contrary to the "frail and sick" stereotypical image held by many. Yet, as a person grows older the likelihood of experiencing illness or disability increases. The 75+ population has been called the "frail elderly" by the Federal Council on Aging, since persons in this age group often require one or several supportive services to cope with daily life, due to development of various chronic conditions (U.S. DHEW, 1978).

Physical Health

Mortality. The population of the United States is living longer than ever before, although this is due more to decreased mortality rates for younger groups than to an increase in longevity of older people. More people are surviving to the age of 65, yet once arriving the chances of developing a chronic disease are a little greater than those of the last two previous generations. About 65% of all deaths in the elderly are attributed to heart disease, strokes and cancer. Heart disease remains the leading cause of death for both men and women (NCoA, 1978). Leading causes of death in Gerontopia during 1977 are noted in Figure IV-A.

Figure IV-A.

LEADING CAUSES OF DEATH BY AGE GROUPS - 1977



*Includes Bronchitis, Emphysema and Asthma

SOURCE: Department of Human Resources, Division of Health Services, Public Health Statistics.

Morbidity. Another set of measures of health status among the elderly population is morbidity rates. Although the older population has a higher incidence of chronic conditions than the younger population, they have relatively low rates of reported acute conditions (NCoA, 1978).

The prevalence of chronic disorders differs among males and females, with older females experiencing considerably higher rates of arthritis and hypertension, slightly higher rates of visual impairments and lower rates of hearing disorders (See Table IV-1). Heart conditions are equally prevalent among both sexes. All chronic conditions with the exception of peptic ulcers are more prevalent among the poor (NCoA, 1978).

Functional Status

An index based on functional abilities of the elderly is often much more useful for describing the health status and related needs of the elderly than mortality and morbidity statistics. Shanas points out that the presence of a particular disease does not necessarily indicate for a given person the inhibition of activity which results from it (Shanas et al, 1968). Shanas (1968) reported that the elderly most often define themselves in ill health only when they are unable to carry out normal activities of their daily routine.

The presence of a chronic physical condition does not necessarily indicate the extent of disability or impairment of function. Although some 81% of the over-65 population suffer from some chronic illness, the Department of Health, Education and Welfare (1979) estimates that about 20% have limitation on major activity and about 17% are unable to carry out major activities. The presence of a functional disability has implications for need: portions of the elderly population may be better assisted by supportive care than by medical regimens called for under the medical model of diagnosis, treatment and cure.

Social and Mental Well-Being

As the definition of health includes aspects of social and mental well-being as well as physical health, various indicators in these areas are helpful in defining need. Social support, physical health and mental health are highly interwoven and it is difficult to separate these factors when defining need.

Old age can be an emotionally healthy and satisfying time of life with few problems of mental and physical impairments. For some, old age can exacerbate old problems, generate new functional disabilities, or bring about a new and difficult phase of life adjustment. The National Council on Aging (1978) divides the mental health status of the elderly into three categories:

- Life crisis reactions: emotional problems such as depression, anxiety and frustration, which may arise from difficulties in adapting to old age.

Table IV-1.

Prevalence of Selected Chronic Conditions per 1,000 Persons by Age, Sex and Race, U.S.

	Arthritis (1969)	Hearing (1971)	Vision (1971)	Hypertension (1972)	Heart Condition (1972)
17-44 years	40	42	32	38	25
45-64 years	204	114	63	127	89
65 years & over					
total	380	294	205	199	199
males	287	338	183	141	199
females	450	262	220	241	198
white	376	299	201	195	200
all other races	425	238	246	249	185

Source: U.S. Department of H.E.W., Public Health Service, Health Resource Administration, National Center for Health Statistics, Health United States 1975, pp. 481, 487, 557, using Health Interview Survey data.

- Functional disturbances: Psychiatric disturbances which cause problems in carrying out normal activities of daily living yet with no actual impairment of brain functioning. These may include anxiety states, depression, alcoholism, schizophrenia or paranoid reactions.

- Organic disorders: Mental disorders resulting from organic brain defects where brain cells have either been impaired or permanently damaged (NCoA, 1978).

The American Psychological Association in 1971 estimated that 13 to 15 percent of the 65+ population, or three million people, were in need of immediate mental health services (in Butler, 1977). These estimates are based primarily on diagnoses of functional disturbances; numbers of persons experiencing life crises reactions and organic disorders are more difficult to estimate. As there is variation in diagnoses depending upon many factors relating to the assessment of mental health problems, figures tend to vary a great deal. However, organic brain disorder is the most commonly used diagnosis for first admissions to mental hospitals (Butler, 1977).

A Needs Statement from a recent annual plan of the Division of Mental Health for the state of Gerontopia makes the following points:

- The elderly population in the four state psychiatric hospitals was 854 as of 1979, comprising at least one-fourth of all psychiatric inpatients.
- A significant number of the elderly patients are placed inappropriately in psychiatric hospital care, and therefore lose their certification for Medicaid reimbursement.
- The placement and follow-up of these patients in appropriate community facilities which have the capability to meet their special needs is a major problem.
- Few community mental health programs have been able to provide additional services due to a lack of resources.
- The number of elderly receiving mental health services is disproportionately low, particularly given the higher incidence of need in contrast to other age groups.

Currently, most services for the elderly in the state of Gerontopia are provided through the adult program. Although the Division of Mental Health Services does not see the need for a totally separate program for the elderly, special needs should be considered. Comprehensive assessments are suggested and should include functioning levels in a number of areas: physical and mental health, activities of daily living, socioeconomic resources, etc. Since outreach, consultation, prevention, and home delivered services generally do not generate third party reimbursement under current rules, it is difficult to provide these services which are often desirable for older individuals.

Social Support; Community and Family Linkages

In contemporary society, successful aging can often be attributed, to a significant extent, to the social supports available to the elderly. Members of an older person's social environment may engage in the following: helping the individual with activities of daily living; providing assistance in linking the older person with activities of daily living; providing assistance in linking the older person with appropriate organizations and institutions; acting as an emotional buffer in times of life crises. Contrary to common belief, most elderly people maintain ties with their families despite rapid societal changes occuring with industrialization and the emergence of new and variant family forms and lifestyles. Yet the myth of broad scale family abandonment of the elderly remains(Brody, 1970). In the United States, only about 5% of those 65 and over are institutionalized. The majority of older people, about 70%, live in family situations (most in their own homes). Only one-fourth of all elderly live alone, although the percentage is higher for women than for men (Carp, 1976).

A needs assessment conducted in Gerontopia in 1979 indicated the following concerning social supports, family and community linkages:

In 16% of households containing at least one person 60 years or older, no one had relatives living in the same county or had contact with relatives in the same county.

. In 4.4% of households containing at least one person 60 years or older, someone had expressed the opinion that the elder member experienced a great deal of loneliness and a lack of interpersonal interactions.

. In 6.6% of households containing at least one person 75 years or older, dissatisfaction with the substantial amount of care this member required was expressed.

. In 8.6% of households containing at least one person 60 years and older, and 9.4% of households containing at least one person 75 years and older, a member experienced one or more crises (e.g. an emotionally significant event or a radical change of status) in the previous six months.

. In 11.9% of households containing one or more persons 60 years or older, someone was experiencing difficulty obtaining transportation in order to carry out necessary daily activities, and in 19.4% of households containing at least one person 75 years or older this barrier was noted.

PART TWO

RESOURCES FOR MEETING NEEDS

Chapter V

INCOME MAINTENANCE

Information on the following sources of income for older people will be discussed in this section: earnings and investments, pensions, Social Security, Supplemental Security Income, and State-County Special Assistance. Both national and statewide figures are presented where available. Brief descriptions of eligibility and coverage of government income-maintenance programs are included.

Chapter V

INCOME MAINTENANCE

Most older persons in the United States retire before or at the age of 65. While some continue to work beyond this age, either full- or part-time, maintenance of an adequate income is necessary to ensure a modest standard of living in old age. Several major state and federal programs provide a primary source of income for many elderly persons. In addition, older individuals may receive income from pension plans to which they contribute during their working years. Table V-1 reflects the major sources of income for older people in Gerontopia and the nation as a whole.

Income from Earnings and Investments

As demonstrated in Table V-2, a number of older persons are still receiving some degree of earnings from wages or salaries. Older non-whites are more likely than older whites to still be in the labor force, and the differences are particularly striking when figures for Gerontopia are compared with national figures.

Older people are less likely to be receiving self-employment and farm income than income from wages and salaries (See Table V-3). However, a number of older persons reported receiving some income from dividends, rent, or trusts and from interest payments. Older whites are much more likely to have investment earnings than non-white elderly persons.

Pensions

An estimated 50 million persons in the United States were enrolled in major private and public pension and retirement programs (other than Social Security) at the end of 1975 (Sourcebook on Aging, 1979). This represents approximately half of all commercial and industrial workers and nearly three-quarters of all civilian personnel. In 1977, persons retiring from the labor force (for a variety of reasons) and their beneficiaries received funds from the following sources (Sourcebook on Aging, 1979):

Private plans:	$14.1 billion for 8.1 million persons
Government-administered plans for civilian employees:	$20.8 billion for 4.8 millions persons
Social Security:	$57.8 billion for 20.8 million retirees
	$27.0 billion for 13.3 million survivors and dependents

Table V-1.

PRIMARY SOURCES OF INCOME FOR PERSONS AGE 65 AND OLDER: U.S. AND GERONTOPIA, 1979

	U.S. (N=23,173,184)	GERONTOPIA (N=459,323)
No Income	2.0%	1.6%
Wages/Salary Only	1.0	1.4
Wages/Salary and Another Source	12.5	14.6
Self-Employment income and Another Source	4.2	7.9
Social Security Only	20.4	27.2
Social Security and Property	24.5	17.7
Social Security and Pension	4.6	4.6
Social Security, Property and Pension	13.6	7.6
All Other Combinations	17.2	17.4
	100.0%	100.0%

Source: U.S. Bureau of the Census. Current Population Survey. March 1979.

Table V-2.

ESTIMATIONS OF INCOME FROM WAGES FOR PERSONS AGE 65 AND OVER ACCORDING TO AMOUNT, U.S. and GERONTOPIA, BY SEX AND RACE (1979)*

U.S.

	Males		Females	
	White	Non-White	White	Non-White
	(N=8,597,626)	(N=949,992)	(N=12,351,569)	(N=1,274,989)
None	80.8%	75.7%	87.6%	88.1%
$1 - 2499	6.1	7.7	8.5	8.0
$2500 - 4999	4.8	8.2	2.4	2.3
$5000 - 9999	2.9	4.4	1.1	1.3
$10,000 +	5.4	4.0	0.5	0.4
	100.0%	100.0%	100.0%	100.0%

Gerontopia

	(N=146,097)	(N=32,244)	(N=213,144)	(N=67,837)
None	76.4%	64.4%	90.5%	80.9%
$1 - 2499	8.4	8.6	3.3	11.2
$2500 - 4999	9.1	7.9	3.3	7.8
$5000 - 9999	4.2	19.1	1.5	---
$10,000 +	4.8	---	1.4	---
	100.0%	100.0%	100.0%	100.0%

Source: U.S. Bureau of the Census. Current Population Survey. March, 1979

*Figures in each column may not add up to 100 percent due to rounding.

Table V-3.

ESTIMATIONS OF INCOME FROM SELF-EMPLOYMENT AND INVESTMENTS FOR PERSONS AGE 65 AND OVER: U.S. AND GERONTOPIA, BY SEX AND RACE (1979)*

U.S.

	Males		Females	
	White (N=8,597,626)	Non-White (N=949,992)	White (N=12,351,569)	Non-White (N=1,274,989)
Self-Employment	6.8%	2.6%	1.8%	2.4%
Farm	3.6	1.7	.9	1.5
Dividends, Rent, Trust	25.0	19.7	19.1	6.4
Interest	64.4	23.7	47.0	16.0
	100.0%	100.0%	100.0%	100.0%
	Gerontopia			
	(N=146,097)	(N=32,244)	(N=213,144)	(N=67,837)
Self-Employment	6.4%	5.5%	-	4.4%
Farm	8.2	7.1	6.3	--
Dividends Rent, Trust	18.4	5.4	19.8	12.8
Interest	54.7	14.7	32.8	13.8
	100.0%	100.0%	100.0%	100.0%

Source: U.S. Bureau of the Census. Current Population Survey. March, 1979

*Figures in each column may not add up to 100 percent due to rounding.

In 1974, the Employee Retirement Income Security Act (ERISA) allowed individuals with no private retirement plans to establish individual retirement accounts (IRAs) which would be tax-free to a limited extend until retirement. Approximately 935,000 persons had set up plans with life insurance companies by the end of 1977, with an average annual reserve of $2,000 per person (Sourcebook on Aging, 1979).

According to national estimates (U.S. Bureau of the Census, 1979), elderly white males (36.8%) are much more likely than white females (18.1%) and older non-white men (11.2%) and women (7.2%) to be receiving pension incomes. Proportionately fewer older people in Gerontopia draw pensions than the elderly in the nation as a whole. This may explain in part the relatively high utilization of the SSI program in the state.

Social Security

Social Security (technically called OASDI: Old-Age, Survivors and Disability Insurance program) is a federally-administered insurance program providing retirement and disability benefits for insured workers, plus benefits for their survivors or dependents. Compulsory contributions from employees and employers finance the program. As an entitlement program which is based upon number of years in the labor force (counted quarterly) and rate of contribution, eligible workers are entitled to benefits regardless of need (State Guide to Law and the Elderly). Hence, approximately 90% of all retired persons age 65 and older receive monthly Social Security payments.

Individuals who elect to retire before age 65 will receive monthly payments which are permanently reduced. Workers between the ages of 65 and 72 (or up to age 70 effective in 1982) will only receive monthly payments if their earned income does not exceed $5,000. Cost of living increases are applied to benefits annually (Social Security Administration, 1980).

As noted in Table V-4, the non-white elderly are less likely to be receiving Social Security payments than are older whites. As many as one-fifth of older minorities nationally may not be receiving any benefits. This may be related in part to earnings requirements, but may also be a function of marital status (as noted in Chapter III, non-white elderly people are more likely than older whites to be widowed or separated/divorced), which can affect eligibility for a spouse's benefits.

The average monthly Social Security benefit for retired workers in Gerontopia increased from $102.18 in 1970 to $216.43 by 1977 (State Statistical Abstract). The average monthly benefit in Gerontopia has been somewhat lower than the national average. Over 860,000 persons in the state received benefits in December, 1978, including almost 500,000 retired workers and their spouses. Total Social Security expenditures in the state for that time period amounted to $86,780,000, with retired workers and their spouses receiving $50,275,000 of the total benefits distributed that month (Social Security Bulletin, 1979).

Table V-4.

ESTIMATIONS OF INCOME FROM SOCIAL SECURITY FOR PERSONS AGE 65 AND OVER ACCORDING TO AMOUNT, U.S. AND GERONTOPIA, BY SEX AND RACE (1979).*

U.S.

	Males		Females	
	White (N=8,597,655)	Non-White (N=949,992)	White (N=12,351,603)	Non-White (N=1,274,989)
None	9.6%	16.4%	9.7%	19.0%
$1 - 2499	21.4	37.0	45.7	56.1
$2500 - 4999	61.1	42.1	42.9	24.9
$5000 - 9999	8.0	4.5	1.8	.1
	100.0%	100.0%	100.0%	100.0%

Gerontopia

	(N=146,097)	(N=32,244)	(N=213,144)	(N=67,837)
None	8.1%	13.7%	6.2%	9.1%
$1 - 2499	32.5	53.2	57.0	72.4
$2500 - 4999	55.1	27.6	35.0	18.4
$5000 - 9999	4.3	5.5	1.8	---
	100.0%	100.0%	100.0%	100.0%

Source: U.S. Bureau of the Census. Current Population Survey. March, 1979

*Figures in each column may not add up to 100% due to rounding.

Supplemental Security Income (SSI)

In 1974, the federally-administered SSI program became effective, replacing state public assistance programs. Persons age 65 and older, blind persons and the disabled receive monthly payments if financial need can be demonstrated. While minimum income and eligibility requirements are nationally uniform, payments vary from state to state; the federal government requires that no individual should receive less than what was received under former state assistance plans, and some states have elected to supplement federal benefits and to vary eligibility requirements (State Guide to Law and the Elderly).

Income eligibility is determined according to a person's income (including Social Security pensions, earnings, etc.) and assets. While ownership of a home is not counted as an asset, living in someone else's household is taken into consideration in the determination of benefits. The maximum monthly benefit is currently $208 for eligible individuals, and $312 for married couples (State Guide to Law and the Elderly).

According to statewide estimates from the 1979 Current Population Survey (U.S. Bureau of the Census), 4.6% of elderly white males and 3.7% of non-white males reported receiving SSI, while 9.2% of elderly white females and over one-fourth of older non-white women (26.7%) were reportedly receiving SSI. National figures were similar for older whites, but among the non-white elderly, a greater percentage of both males (16.2%) and females (32.4%) indicated that they received financial support from the SSI program.

In December 1977, 157 elderly persons per thousand population over age 65 in Gerontopia were receiving SSI, ranking the state ninth in the country (in number of recipients per thousand elderly). This may be related to the state's relatively low rank of 23 in number of recipients per thousand population age 65 and over of Social Security for that time period (Social Security Bulletin, 1979).

State-County Special Assistance

Gerontopia has elected to provide additional financial benefits to residents age 65 and older who are permanently and totally disabled, and/or needy. Assistance is provided to two groups of older persons: 1) those who must not receive less assistance under SSI than they did before this program was initiated, and 2) needy aged or disabled adults requiring domiciliary care who were not receiving state aid prior to the implementation of the SSI program (State Guide to Law and the Elderly).

Income eligibility requirements take into account the value of reserves, assets, non-essential property, earned income, and the value of unearned income (eg. OASDI, SSI, pensions, etc.). While over 35,000 persons were receiving State-County Special Assistance funds in FY 1972, the introduction of SSI in 1974 was associated with a sharp drop in recipients for that fiscal year (6,800). By FY 1978, only about 5,800 persons were being served under the program. The average payment more than doubled from $71.79 in FY 1972 to $159.63 in FY 1978. Only a very small proportion of the elderly population of the state now receives income from State-County Special Assistance (State Statistical Abstract).

Chapter VI

HOUSING

In this section, the distribution of the housing units in which older people live are noted. Federal housing initiatives are described, especially those coordinated by the Department of Housing and Urban Development (HUD) and the Farmer's Home Administration (FmHA). State and local housing efforts are also mentioned as well as the involvement of non-profit organizations in sponsoring housing for the elderly. Several innovative concepts in housing (congregate housing and foster home care) are discussed.

CHAPTER VI

HOUSING

Housing costs comprise the largest single expenditure for most people, and especially for the elderly. Elderly renters allocate roughly one-third of their income, on the average, for rent; older homeowners spend close to 10% of their income on property taxes, twice the rate paid by homeowners in general. As many as one-third of persons age 65 and older in the U.S. live in substandard, deteriorating, or dilapidated housing. (Sourcebook on Aging, 1977)

According to estimates from the Current Population Survey conducted in March, 1979 (U.S. Bureau of the Census), a majority (94.4%) of the country's non-institutional elderly live in homes or apartments. Approximately 5% live in mobile homes or trailers. The remaining 0.6% reside in hotels (transient and non-transient), rooming houses, and non-housing units.

Older whites are more likely than non-whites to live in mobile homes and trailers, while a greater proportion of non-white elderly live in hotels. This difference is probably a reflection of the higher income levels of older whites. Non-white elderly are also more likely to rent a home or apartment or to live in public housing, compared to estimates for elderly whites (See Table VI-1).

Federal Housing Initiatives

The federal government has provided some assistance to older Americans in meeting their housing needs. Direct aid has been available to elderly renters and homeowners in the form of loans, grants, and subsidies. Loans and grants have also been available to developers who have been interested in building housing specifically for the elderly, or who were willing to let low-income persons reside in their facilities. While close to half (44%) of all public housing residents are at least 65 years of age (U.S. Dept. of Housing and Urban Development, 1979) the vast majority of older persons in the country do not participate in federal housing programs. A Senate report in 1974 (Newcomer, 1976) estimated that only 3% of all older people lived in federal housing projects. However, many elderly homeowners receive tax relief for property taxes, deductions of interest payments, etc.

The Department of Housing and Urban Development (HUD), and the Farmer's Home Administration (Department of Agriculture) coordinate most housing programs for urban and rural elderly. The Administration on Aging also funds research and demonstration projects relevant to the housing needs of older Americans.

Table VI-1.

NATIONAL ESTIMATES OF OLDER PERSONS WHO OWN OR RENT THEIR RESIDENCES, BY SEX AND RACE, 1979

	MALES		FEMALES	
	WHITE (N=8,597,107)	NON-WHITE (N=949,993)	WHITE (N=12,351,090)	NON-WHITE (N=1,274,988)
own or paying for residence	83.0%	68.3%	75.6%	63.1%
public housing rental	1.4	5.2	2.8	8.3
non-public housing rental	15.6	26.5	21.6	28.6
	100.0%	100.0%	100.0%	100.0%

Source: U.S. Bureau of the Census. Current Population Survey, March, 1979.

Rent assistance is the primary emphasis in terms of urban housing. Subsidies to individuals are designed as compensation for the difference between the individual's ability to pay for a unit and the fair market rate. Developers may also receive low-interest or subsidized loans for housing in which low-income elderly are accepted (State Guide to Law and the Elderly).

Increased attention is being directed within HUD toward special housing needs of older people. First, the development of auxiliary services (e.g. social services) is being explored. Second, pilot projects are being initiated under the Congregate Housing Services Act of 1978. The goal of these projects is to design a group living environment which will ultimately prevent premature or unnecessary institutionalization of healthy older adults who have functional impairments (State Guide to Law and the Elderly).

The Farmer's Home Administration places a greater emphasis on home-ownership than rental assistance by offering the following: low interest loans to low-income homeowners, interest subsidies to low- and moderate - income home buyers, and home improvement grants to elderly low-income homeowners. Interest subsidies for construction of low-income rental or cooperative housing is also available (State Guide to Law and the Elderly).

Relief from the high costs of housing for the largest number of older Americans occurs through federal tax deductions. All homeowners can make deductions for mortgage interest rates, and 60% of all elderly homeowners benefited from this at the time of the 1970 Census (Baer, 1976).

Persons age 55 and older who sell a house in which they have lived for at least three of the five years preceding the sale can be exempt from federal capital gains taxes. As a once-in-a-lifetime benefit, the taxpayer may exclude a gain of up to $100,000 from income for that year.

State and local efforts

Many states offer some form of tax relief to benefit residents who are income-eligible. Two of the most common provisions are homestead exemptions (reduction of the assessed value of homes) and circuit breakers (reduced tax liability for low-income households). The state of Gerontopia offers homestead exemptions. On the local level, many eligible residents may be charged reduced rates for utilities (Sourcebook on Aging, 1977).

Gerontopia does not have a policy-making housing agency, but several committees have been formed at various administrative levels (the Rural Development Coordinating Committee and the Interagency Task Force on Housing for the Handicapped). The Title XX program within the Department of Human Resources offers two housing-related programs which are available to older adults: foster care for adults (description will follow) and housing/home improvement. The latter program is designed to assist residents in maintaining an adequate standard of housing.

The program includes services such as relocation, the provision of labor and materials for minor repairs to owner-occupied dwellings, and dissemination of essential appliances (a county option). The FY 1980-81 budget allots $368,000 to serve roughly 3,000 residents of the state (State Division of Social Services, Comprehensive Annual Services Plan).

Other developments in housing

Non-profit religious groups, community-based organizations, fraternal organizations, and other voluntary or membership groups have played an active role in sponsoring housing projects for the elderly. Eighty-five percent of 220 projects utilizing funds from HUD under sections 202, 231, 202/236 and 236 were sponsored by non-profit organizations (U.S. Department of Housing and Urban Development, 1979).

Several innovative concepts in providing alternatives to traditional modes of housing are now in operation. In a study of 27 congregate housing sites reported in the 1977 Sourcebook on Aging, the sites offered an integrated housing and services package in a non-institutional group living environment. Primarily housing older people (72.5% of the residents studied were 75 or older, although most moved in at a younger age), the only service common to all sites was the provision of meals. However, most projects provided an array of auxiliary services, with a mean of nine services per site among the 27 studied in the mid-1970's.

Foster home care is also increasingly being seen as a viable alternate to institutional care for older adults with special housing needs. It essentially consists of a housing arrangement with non-relatives for minimally-impaired adults. In Gerontopia, Title XX funds are projected to serve over 12,000 low-income aged, blind, and disabled persons, with expenditures amounting to almost one million dollars for the total program in FY 1980-81. As a mandatory social service, the foster care program for adults also involves examination and development of family care homes and group care facilities (State Division of Social Services, Comprehensive Annual Services Plan).

Chapter VII

SOCIAL SERVICES AND TRANSPORTATION

Mandatory and optional social services pertinent to the elderly which are funded by Title XX of the Social Security Act are first described. Social services provided under the Older Americans Act are then discussed, followed by a summary of the Food Stamp Act. Information on the number of clients served, and the funding and administration of each of these programs are provided. The section concludes with a discussion of transportation services for the elderly.

Chapter VII

SOCIAL SERVICES AND TRANSPORTATION

Social Services

Though in the narrow sense, social services may be thought of as auxiliary services attached to medical services or public assistance programs, in the broadest, most positive sense, they include those community services necessary to maximize the potential of the individual and insure a quality of life which the individual or his family is not able to provide. Taken in this sense, social services include a broad range of activities performed not just for the poor or ill, but also for those in need of friendship, counsel or increased self-esteem. While they imply activites in which all people, as semi-independent beings, must participate to a greater or lesser extent, the elderly are particularly in need of such services, as the later years often bring not only increased physical and economic vulnerability, but decrease in family and other informal support systems.

Social services are performed to a great degree by individuals and volunteer organizations such as churches and civic groups, but over the years much of the responsibility has been transferred to the State, and has come down to us as federal legislation. At present, much of what is most commonly conceptualized as social services is performed by programs funded under Title XX of the Social Security Act. An additional legislative mandate, the Older Americans Act, provides a structure and funding which promote the well being of the elderly through a number of community programs. One other single piece of legislation, the Food Stamp Act, is a source of financial relief to a number of poorer persons, and could be of special benefit to those elderly on fixed incomes. Though social services are often provided as a secondary aspect of other governmental service programs, only three major programs will be briefly discussed here.

Social Services under Title XX

Background

Title XX of the Social Security Act became law in January of 1975. The five goals of Title XX, as defined by federal legislation, include 1) economic self-support; 2) personal self-sufficiency; 3) preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families; 4) preventing or reducing inappropriate institutional care; and 5) securing institutional care when appropriate or providing services to those in institutions.

Title XX was designed to allow states flexibility in the services offered, within the following guidelines: Federal regulations require that all counties provide at least one service directed towards each of the five programs goals; at least three services for aged, blind or disabled persons receiving Supplemental Security Income (SSI); family planning services for recipients of Aid to Families with Dependent children (AFDC) upon request; and foster care services to AFDC-Foster Care recipients (State Guide to Law and the Elderly; Division of Social Services, Comprehensive Annual Services Plan).

Services for the elderly

In order to comply with federal and/or state regulations, Gerontopia requires that each county provide twelve "mandated services". In addition, counties may offer a range of optional services (Division of Social Services, Comprehensive Annual Services Plan). See Table VII-1 for a complete list of services and the number of counties in Gerontopia which provide each service.

The following are mandated services which may directly benefit older adults:

- Foster Care Services for Adults - Provides assistance in finding licensed substitute homes to meet the needs of individuals who are unable to remain in their own homes or who need to move out of institutional care. These services include assessment and counseling of the individual as well as licensing and technical assistance in the development of family care homes and group care facilities.

- Health Support Services - Aids individuals and families in recognizing health needs, and in securing needed health services. Provides counseling and planning to assure continuity of treatment and the implementation of health recommendations.

- In-Home Services: Chore or Homemaker Services - As required by federal mandate, each county must provide either chore or homemaker services. Both services offer help to eligible individuals in their own homes, for several hours a day, in such tasks as grocery shopping, household chores, and personal care. The object of such services is to enable individuals to remain in their own homes, when they are unable to carry out such activities for themselves, and where no other responsible person is available for this purpose. In addition, homemakers, who are paraprofessionals trained under National Homecaring Council Standards, provide assistance in household management, budgeting and child care.

- Protective Services for Adults - Provides services to correct or prevent abuse, neglect, exploitation or hazardous living conditions of individuals who are unable to manage their own resources, carry out the activities of daily living or protect their own interests.

Optional services that may benefit older adults include:

- Day Care Services for Adults - Provides a day-long, five day per week program of organized activities in a certified facility to impaired older adults.

- Housing and Home Improvement - Provides assistance in minor repairs, in obtaining basic appliances such as stoves, refrigerators or heaters, and in obtaining adequate housing.

- Preparation and Delivery of Meals - Provides nutritious meals to blind, aging or disabled individuals in their own homes or in a central dining facility as necessary to prevent institutionalization or malnutrition.

- Social Development through Therapeutic Group Services - Provides structured group activities designed to help individuals cope with personal problems and to develop capacities for more adequate social and personal functioning, to relieve social isolation, and to increase understanding between the group and the services agency.

- Services to Meet Special Needs of the Aging, Disabled or Handicapped. Provides counseling and casework assistance to help individuals choose, obtain and use needed resources, services and mechanisms of support. Provides interpreters for the deaf, telephones, ramps, rails, and other safety measures at the individual's home, as well as escort services for individuals unable to travel or wait alone; arranges for friendly visitors or companions to visit with those who have limited contacts with other people; provides, without cost, health supplies such as oxygen, bandages, orthopedic and other appliances not available through Medicaid, Medicare or other resources.

- Transportation - Enables individuals for whom transportation is not otherwise available to have access to medical and health resources, shopping facilities, education, recreation and employment and training opportunities. Supports the delivery of other social services.

Clients served

Those eligible for services fall into one of three categories: 1) AFDC recipients 2) Supplemental Security Income recipients and 3) income-eligibles. Income-eligibles are those needy individuals whose income is less than or equal to a certain income level. Depending on the service for which they wish to qualify, they must make less than either 60%, 80% or 100% of the "maximum allowable income". This maximum income level is set by each state, and may be as high as 115% of the median income for a family of four (with adjustments made for family size). Gerontopia has set its maximum income level at 100% of the median income, which in 1980-81 was figured to be $11,052 for a family of two. Fees for services are required of anyone whose income is greater than 80%, and in some cases 60%, of the maximum income level. Some services are provided to needy persons regardless of their income (Division of Social Services Comprehensive Annual Services Plan). The number of clients estimated to be served under the various income categories can be seen Table VII-1.

Table VII-1.

SUMMARY OF ESTIMATED CLIENT AND SPENDING LEVELS BY SERVICE

INCOME LEVEL (% established income) 80%	80%	100% w/O regard to income	SERVICE	INCOME MAINT. CLIENTS	INCOME MAINT. DOLLARS	INCOME ELIGIBLE CLIENTS	INCOME ELIGIBLE DOLLARS	W/OUT REGARD CLIENTS	W/OUT REGARD DOLLARS	TOTAL XX CLIENTS	TOTAL XX DOLLARS	local level provision # COUNTIES	state level contract # COUNTIES
	x		*ADOPTION SERVICES	1,380	249,924	6,081	588,584	263	23,302	7,724	861,810	100	
	x		COMMUNITY LIVING SERVICES	1,697	2,740,241	839	1,657,770	0	0	2,536	4,398,011	5	100
	x		COM. LIVING SVCS. TRANSP.	212	22,633	137	7,398	0	0	349	30,031	2	37
		x	DAY CARE FOR ADULTS	230	267,153	118	131,420	1	117	349	418,690	10	3
		x	ADULT DAY CARE-TRANSPORTATION	225	42,188	114	24,272	1	117	340	66,577	10	3
		x	*DAY CARE FOR CHILDREN	4,469	3,595,462	5,408	4,438,044	71	61,405	9,948	8,094,911	100	
		x	CHILD CARE-TRANSPORTATION	1,360	274,372	1,664	326,683	22	2,770	3,046	603,825	82	33
		x	DEVELOPMENTAL CHILD DAY CARE	816	1,043,447	1,016	1,221,018	27	39,901	1,859	2,304,366	56	100
		x	[illegible]V. CHILD DAY CARE-TRANS.	245	146,854	319	155,605	14	3,903	578	306,362	45	47
	x		[illegible]/NIGHT TREATMENT, ALCOHOL	3	3,819	57	72,574	0	0	60	[illegible]	0	1
	x		DAY TREATMENT, ED	107	144,471	153	201,786	10	14,105	270	360,362	1	14
	x		DAY/NIGHT ALCOHOL TRANSP.	0	0	0	0	0	0	0	0	0	0
	x		DAY TREATMENT, ED TRANSP.	64	11,909	94	17,143	6	1,140	164	30,192	0	10
	x		DELINQUENCY PREVENTION	1,163	105,353	1,034	94,372	244	21,967	2,441	221,692	54	0
	x		DELINQUENCY PREV-RESIDENTIAL	31	66,502	33	76,370	9	15,712	73	158,584	6	0
x			EMPLOYMENT AND TRAINING	1,701	119,139	846	67,820	32	2,447	2,579	189,406	48	100
x			EMPLOY. AND TRNG., TRANSP.	161	7,598	65	2,672	1	4	227	10,274	6	100
	x		*FAMILY PLANNING SERVICES	9,919	214,194	71,662	2,791,049	516	13,360	82,097	3,018,603	100	
	x		FAMILY PLANNING TRANSP.	98	1,793	394	7,733	1	16	493	9,542	20	0
	x		*FOSTER CARE FOR ADULTS	8,649	608,566	3,996	287,539	84	5,494	12,729	901,599	100	
	x		*FOSTER CARE FOR CHILDREN	5,275	922,700	7,664	1,350,877	779	135,999	13,718	2,409,576	100	
	x		CHILD FOSTER CARE-RESIDENTIAL	134	62,324	195	91,442	20	8,759	349	162,525	5	0
	x		*HEALTH SUPPORT SERVICES	40,386	1,557,785	20,126	743,876	1,072	32,036	61,584	2,333,697	100	
	x		HEALTH SUPPORT TRANSPORTATION	8,301	225,274	3,683	99,382	210	4,734	12,194	329,390	51	100
	x		HOME BASED TRAINING	244	316,411	228	302,407	11	14,552	483	633,370	0	62
	x		HOUSING AND HOME IMPROVEMENT	2,314	278,229	679	81,448	40	8,760	3,033	368,437	48	100
	x		*INDIVIDUAL AND FAMILY ADJUST.	34,231	2,212,229	27,157	1,948,641	2,974	148,010	64,362	4,308,880	100	
		x	INFORMATION AND REFERRAL	56,594	369,716	28,353	238,179	55,206	533,818	140,153	1,141,713	74	100
		x	**IN-HOME--CHORE	2,999	3,634,812	1,676	2,042,527	22	31,506	4,697	5,728,845	87	7
		x	**IN-HOME--HOMEMAKER	7,822	1,161,091	2,828	431,413	427	67,817	11,077	1,660,321	58	0
	x		PERSONAL AND FAMILY CNSLNG.	522	83,646	189	30,829	48	7,382	759	121,857	10	0
		x	PREPARATION AND MEAL DELIVERY	277	99,285	721	227,584	6	1,628	1,004	328,497	12	1
	x		PROBLEM PREGNANCY	880	44,844	1,974	109,536	9	199	2,863	154,579	81	0
	x		PROBLEM PREG.-RESIDENTIAL	32	51,104	30	47,961	0	0	62	99,065	0	100
		x	*PROTECTIVE SERVICES-ADULTS	1,896	189,056	1,173	121,926	2,242	223,867	5,311	534,849	100	
		x	*PROTECTIVE SERVICES-CHILDREN	14,439	863,013	5,944	379,871	25,795	1,617,124	46,198	2,860,008	100	
	x		RESIDENTIAL SRVCS, ALCOHOLICS	41	36,405	713	488,699	3	7,961	757	533,065	0	64
	x		RESIDENTIAL TREATMENT, ED	56	311,894	230	1,131,134	19	90,328	305	1,533,376	13	100
	x		SRV. AGING, DELBD, HNDCPD.	2,702	318,942	1,336	152,635	21	2,003	4,059	473,580	47	100
	x		*ADJUSTMENT SER. FOR THE BLIND	6,974	1,199,050	1,213	197,318	22	4,106	8,209	1,400,474	100	
		x	*CHORE SERVICES-BLIND	1,156	885,437	407	313,259	0	0	1,563	1,198,696	100	
x			SOCIAL DEV. THRU GRP. SRVCS.	1,130	227,000	416	249,192	37	28,776	1,583	504,968	16	100
x			TRANSPORTATION SERVICES	22,087	822,547	8,966	369,101	596	19,143	31,649	1,210,791	81	100
			FINAL TOTALS	243,042	25,558,412	209,931	23,339,109	90,861	3,194,268	543,834	52,091,789		

*Mandatory Service

**Must choose either chore or homemaker as one service

Source: State Final Title XX Comprehensive Annual Services Plan for FY 1981.

Funding and Administration

Federal funds for Title XX are allotted to states on the basis of each state's percentage of the total U.S. population. States are required to contribute one dollar for every three federal dollars (except in the case of family planning services, in which the state must contribute one dollar for every nine federal dollars). For the 1980-81 fiscal year the federal funds allotted to Gerontopia were $74,167,335. The matching state funds may come from nonfederal public or private sources at the State or local level (Division of Social Services,Comprehensive Annual Services Plan).

In Gerontopia, the Department of Human Resources (DHR) administers the Title XX program. One of the divisions of DHR, the Division of Social Services, supervises the delivery of Title XX and other social services through the county departments of social services.

Planning Process

Each year the Department of Human Resources must develop a Comprehensive Annual Services Plan (CASP) that specifies the services to be offered, the method of delivery for each service (whether directly by the state agency or by private agency), the categories of persons eligible for the service, and the geographic regions in which the service is to be made available.

The Center for Urban Affairs at the State University conducts a statewide needs assessment which is used in forming the plan (State Title XX Needs Assessment). As Federal regulations require that all residents' needs must be considered in developing the plan, public participation is necessary. DHR has thus established ten Title XX advisory committees across the state, composed of 200 interested citizens and 100 recipients of Title XX services, who make recommendations to DHR for program improvements.

The number of clients and spending level for each service for the coming year is estimated (See Table VII-1) and appears in the CASP manual (Division of Social Services).

Social Services under the Older Americans Act

Background

Title III of the Older American Act (OAA) provides funds for social services to older Americans. The program was begun in 1966 and was revised and expanded with the 1973 and 1978 amendments to the OAA. In addition, Title V of the OAA provides employment opportunities for the low-income elderly (U.S. Dept. of Health, Education, and Welfare, 1979).

Services under Title III

Under Title III, comprehensive and coordinated service systems were to be developed in order to 1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive services; 2) remove individual and social barriers to economic and personal independence for older individuals; 3) provide a continuum of care for the vulnerable elderly.

Each Area Agency on Aging is required to spend at least 50 percent of its social service allotment for the delivery of services associated with ensuring access to services, in-home services and legal services. Some funds must be expended in pursuit of each of the three objectives (State Guide to Law and the Elderly).

The following social services are supported with Title III funds:

- in-home services (homemaker, chore, and home health)
- housing assistance (counseling, home renovation, and repair)
- transportation
- legal services
- information and referral
- outreach
- health screening
- counseling
- employment referral services

In addition, Title III funds the Nutrition Program (formerly funded under Title VII, OAA). This service provides nutritious home-delivered meals five days a week, to older adults (60+) and their spouses who are confined to their homes because of poor health, and a [illegible]h-time congregate meal five days a week at conveniently located sites [illegible] as senior citizen centers, schools or churches. Nutrition programs exist or are planned for all counties in Gerontopia (State Guide to Law and the Elderly).

Senior Centers (formerly funded under Title V, OAA) are also funded under Title III. The funding provides for the operation, renovation, and construction of multipurpose senior centers (U.S. Dept. of Health, Education, and Welfare, 1979).

Clients Served. Anyone aged 60 and over is eligible to receive these services; however, special emphasis must be given to serving those older persons with the greatest economic or social need. The number of clients served in the state under Title III funds for the 1979-80 fiscal year may be seen in Table VII-2.

Table VII-2.

Number of Clients Served in the State
under Title III of the Older Americans Act in FY 1979-80

	minority	low-income	total
Social Services			
Transportation	19,997	36,889	43,542
Homemaker	1,058	2,598	3,150
Home Health	393	,922	1,064
Other Health	1,084	3,384	3,703
Legal	3,614	6,514	9,322
Home Repair	777	1,403	1,459
Information And Referral	11,993	31,728	59,073
Outreach	6,936	14,992	22,650
Other Services			
Housing Assistance	341	1,765	1,913
Counseling	467	1,892	2,611
Health Screening	1,513	4,112	9,204
Employment Referral	181	272	306
Other	1,771	3,495	4,773
	50,125	109,957	160,770

Services under Title V

The Senior Community Services Employment Program is operated under Title V (formerly Title IV) and administered by the Department of Labor. Its purpose is to promote part-time opportunities in community services programs for those over 55 who are unemployed and have little income. Title V funds up to 90% of the program costs (U.S. Dept. of Health, Education, and Welfare, 1979).

Clients served. Of those unemployed, low-income persons age 55 or over, the program focuses on those who have especially poor income prospects. Approximately 300 positions were funded under Title V funds for the 1979-80 fiscal year (State Division of Aging).

Funding and Administration of OAA

Funds for Aging Services are made available to the Division of Aging (of the Department of Human Resources) by the Administration on Aging of the U.S. Department of Health and Human Services (DHHS). In general, funds must be matched on a nine-to-one basis. The Division of Aging makes grants to Area Agencies on Aging, which are multicounty aging programs (State Guide to Law and the Elderly). Services are provided through contracts with local service providers (either public or non-profit private agencies or organizations).

Planning Process for OAA Services

Each Area Agency must develop a comprehensive three-year plan for the provision of services to older adults in that area. This plan is submitted to the Division on Aging, which with input from the Governor's Advisory Council on Aging, develops and submits to the Administration on Aging a three-year State Plan on Aging. Public Hearings on the State Plan allow citizen participation (State Guide to Law and the Elderly).

FOOD STAMP PROGRAM

The Food Stamp Act was passed by the federal legislature in 1964, and is now operative in all states. The program was activated in Gerontopia in 1974. The purpose of the program is to insure that low-income households have access to nutritionally adequate diets (State Guide to Law and the Elderly).

Services

Eligible participants are issued food stamps which can be spent in place of money for food products. The amount of the food stamp allotment for a household is based on the number of persons in the family and the household's net monthly income.

Clients served

Individuals whose household's net monthly income and resources are less than a certain amount (dependent upon the number of individuals in the household) are eligible for food stamps, provided that all able-bodied household members aged 18 to 59 (with some exceptions) are registered for work. As of October, 1980 the maximum allowable resource value (e.g. bank accounts, stocks and bonds, certain real estate) of the household is set at $1500. If at least one member of the household is age 60 or older, the upper limit on resources is $3000. The maximum net monthly income, after deductions, for a household consisting of one person is $316; two persons, $418; three persons, $520. Those elderly eligible for meals programs may use their food stamps to pay for those services. Approximately 608,000 persons received food stamps in Gerontopia in 1979 (Local Department of Social Services).

Funding and Administration

The Food and Nutrition Service of the Department of Agriculture has responsibility for this program at the Federal Level. In Gerontopia, the Division of Social Services administers the program at the state level, while at the county level, the program is administered to recipients through the County Departments of Social Services. The cost of food stamps themselves is paid for by the federal government. Administrative costs are paid primarily out of county or federal funds (State Guide to Law and the Elderly).

Transportation Services

Older people are among four groups (the poor, the handicapped, the elderly and youths) in Gerontopia who have special transportation needs. Due in some cases to failing physical capabilities which curtail driving or to lack of money to support the ownership and operation of their own vehicle, the elderly must often depend on public transportation as well as on rides from friends and relatives to maintain themselves in the community.

Though no exact figures are available, it is known that a large percentage of the need for transportation is met by the informal support system: friends, relatives and neighbors. In the event of unavailability of help from these groups, the needy elderly must rely on buses, taxis, human service vehicles, or rides from members of volunteer groups. This section describes the availability and use by the elderly in Gerontopia of organized transportation services.

Taxis

A 1977 study of taxicab services in Gerontopia (State Rural Transportation Report) revealed a number of facts. Eighty-seven of the 100 counties had taxicab service. In terms of cities and towns, 39% had taxicab service (100% in cities with over 10,000 persons, 89% in towns of population 5000 to 10,000, and 26% in towns of less than 5000 persons). The total number of taxis in operation was 2541. In comparison to the population as a whole, riders were more likely to be

elderly (20%, as compared with 12% in Gerontopia's population aged 60 or older); were more likely to have low incomes (53%, as compared with 23% in the population with incomes less than $5000); and were more likely to be black(59%, as compared with 23%; in the population). Taxis were found to be used primarily for short, essential trips. Sixty percent of the fares were less than $1.50. (Tips to cab drivers were so small and infrequent as to be negligible.)

Due to rising costs of fuel and inflation-induced factors, taxi services have experienced profit declines, resulting in a drop in the number of operating taxis, and have had to increase fares, resulting in some loss of ridership. Nevertheless, taxis remain one of the most viable transportation services for low income elderly in Gerontopia, and several innovative programs have been initiated to ease the financial burden; these include a shared-ride taxi program to replace more-expensive-to-operate night bus service, and a user-side taxi subsidy for the elderly and handicapped, sponsored by the Urban Mass Transportation Administration (State Rural Transportation Report).

Intracity bus services

Only 18 cities in Gerontopia have either publicly or privately owned bus systems. No city under 10,000 persons has a bus system, and only one bus system (with one bus) exists in cities in the 10,000 to 25,000 population range. Still, in those cities in which it is available, the bus system provides an often vital means of mobility, particularly for those low income persons without other reliable transportation. Fares typically range from 25 to 45 cents, with discounts for senior citizens (State Rural Transportation Report).

Intercity bus services

The intercity bus system (operated by a number of privately owned companies) is a major provider of transportation in Gerontopia as in the rest of the United States, serving not only the major cities, but the smaller communities and rural areas which may have no alternative public transportation. In 1977, there were 27 bus companies operating in Gerontopia. From 1967 to 1977, there had been a decline in passengers, coupled with an increase in operating expenses, resulting in decreased revenues and cut-backs in the number of bus-miles operated. Nevertheless, in most sections of the state, intercity bus services were rated good to excellent. With the recent sharp rise in gasoline prices, estimates are that bus ridership is again on the increase. The elderly, who are particularly vulnerable to the effects of inflation, are favored by the bus industry with a 13% discount on all fares nationwide (State Rural Transportation Report).

Church vehicles

Religious organizations often offer limited but important transportation services to their members, picking them up at their homes to attend religious programs and related functions, and bringing them back. A 1976-77 sample survey found that 44% of churches in Gerontopia had at least one vehicle for such purposes. Those churches without vehicles

usually relied on their members to provide volunteer services with their private automobiles. State law and insurance policies discourage the use of such vehicles for non church-related purposes (State Rural Transportation Report).

Human Services Transportation

Human services agencies, such as those supported by funds from Title XX of the Social Security Act and Title III of the Older Americans Act, often provide transportation to and from their own programs as well as to medical and health resources, shopping facilities, education, recreation, and employment and training opportunities.

A recent survey conducted by Gerontopia's Departments of Transportation and Human Resources found that human services agencies in 74 out of 100 counties had vehicles used in transporting their clients. When those counties served by agencies in adjacent counties were taken into account, the total number of counties served by transportation vehicles was 97. Of the 1002 vehicles registered to various human services agencies in Gerontopia, only 9% of them were equipped to transport the handicapped (State Rural Transportation Report).

Chapter VIII

HEALTH SERVICES AND FACILITIES

Major sources of funding for health care of the elderly are described, as well as services and facilities providing care. Coverage and administration of Medicare and Medicaid are first discussed, followed by information on the types of private health insurance utilized by older persons. Relative expenditures for health care by private and public sources of funding are noted. This is followed by information on the following sources of health care provision: private medical practice, the Veterans Administration, public health departments, home health, adult day care, short-term hospital care, long-term care, homes for the aged and family care homes, and voluntary organizations.

Chapter VIII

HEALTH SERVICES AND FACILITIES

Health care services are funded for the elderly by several major federal programs, as well as by programs at the state and local level (See Figure XIII-1).

Program auspices may include public, private not-for-profit or proprietary (private-for-profit). Three major routes of payment for health care are direct payments from consumer to provider, through government, and through private insurance companies (profit and non-profit) (Jonas, 1977). The common settings for delivery of long-term care are: in-home, family care homes, intermediate care facilities (ICF's), skilled nursing facilities (SNF's), adult day care centers, mental hospitals and mental retardation centers.

Funding and Expenditures

Medicare

Medicare (Title XVIII of the Social Security Act) is a federally sponsored health insurance plan for the elderly and disabled. The Medicare Program consists of two separate but coordinated parts:

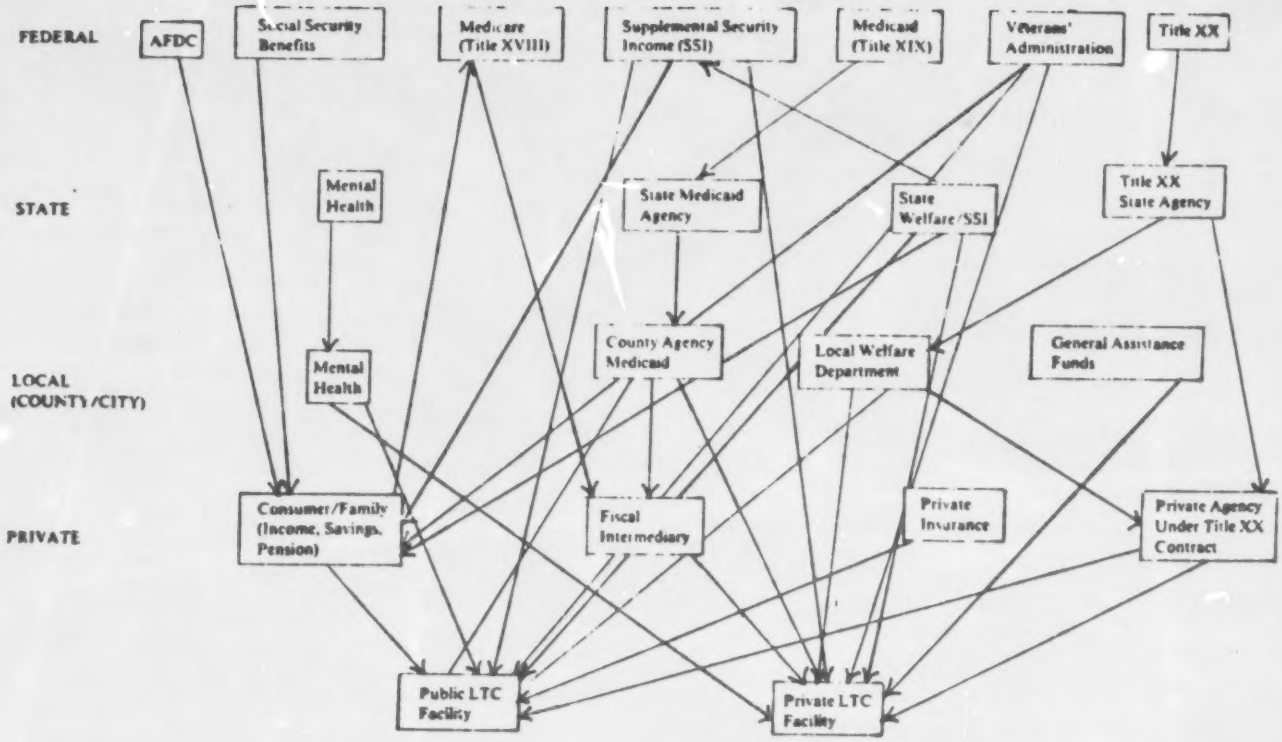
- Part A, hospital insurance, is generally financed by special Social Security taxes, thus having some prior cost sharing requirements. This covers inpatient hospital service, and certain post-hospital care in skilled nursing facilities and in patients' homes.

- Part B, supplementary medical insurance, covers physician services, hospital outpatient services, additional home health care, laboratory,pathology and radiologic services.

No premiums are charged for benefits under Part A, though coinsurance payment is required for some services. All those 65 years or older who qualify for Social Security or Railroad Retirement plus those under 65 who have received cash benefits on disability for 24 months are eligible for these benefits. Some people who have severe kidney disease are also eligible. Participation in Part B is voluntary for anyone eligible for Part A,and is available for a small monthly fee (Social Security Administration, 1980).

Figure VIII-1.

LONG-TERM CARE FINANCING: FLOW OF FUNDS



Source: Joe, Tom and Judith Meltzer. "Policies and strategies for long-term care." Journal of Long Term Care and Health Services Administration Quarterly, 1(3): 197-227, Fall 1977.

Medicare is federally administered by the Health Care Finance Administration (HCFA) of the Department of Health and Human Services (DHHS). Public and private insurance organizations act as fiscal intermediaries under contract with the federal government. These intermediaries are primarily responsible for (1) making reasonable payments for services provided, (2) serving as a mediator between agencies and HCFA, and (3) assisting in applying safeguards against the use of unnecessary program services. In Gerontopia, fiscal intermediaries for Medicare are Blue Cross-Blue Shield and the Prudential Insurance Company (State Guide to Law and the Elderly).

State agencies, in an agreement with the Health Care Financing Administration(HCFA) are responsible for inspecting and certifying the providers of medical services (hospitals, nursing homes, and home health agencies) to insure that they meet the requirements for participating in the Medicare program. This responsibility is undertaken by the Division of Facility Services of the Department of Human Resources (State Guide to Law and the Elderly).

Medicare is primarily an acute care program, as is evidenced by the following breakdown of 1975 Medicare expenditures by service (See Table VIII-1). Inpatient hospital services and physician services combined accounted for slightly more than 90% of these expenditures, while skilled nursing expenditures accounted for 1.89%,outpatient services comprised 4.25%, and home health a mere 1.3%.

Medicaid

Medicaid (Title XIX of the Social Security Act) is a federal/state medical assistance program for the indigent and near indigent. While Medicare is an insurance program, Medicaid is a welfare program, with eligibility for Medicaid based on need and whether the needy person fits into certain categories (e.g., degree of need).

Benefits under the Medicaid program vary from state to state, yet the following services are mandatory for the categorically needy (i.e., persons who meet income eligibility criteria): (1) inpatient hospital services, (2) outpatient hospital services, (3) skilled nursing facility services, (4) physician services whether rendered in the office,the patient's home, a hospital, or a nursing home, (5) home health services, and (6) services to assure transportation to and from medical services. In Gerontopia as in many states the scope of services which may be offered under Medicaid is considerably broader than services provided by Medicare.

Gerontopia has a complex set of rules for eligibility; the county departments of social services are responsible for eligibility determination. In measuring income and need, the eligibility factors are projected over six month periods called certification periods. If income exceeds the amount calculated as need, the excess becomes a deductible, or a "spend-down". Certain types of services must have prior approval to be covered by Medicaid. In these instances the fiscal intermediary decides whether each case is in compliance with federal and state policies (State Guide to Law and the Elderly).

Table VIII-1.

Federal Medicare Expenditures, FY 1975
(in millions)

	HI[a]	SMI[b]	Total	Total $	% of Total $
Persons Enrolled					
Aged	21.6	21.5			
Disabled	2.1	1.8			
Received Services					
Aged	4.9	11.2			
Disabled	.6	1.4			
Benefits					
Inpatient Hospital					
Aged	$ 9,033		$ 9,033	$9,954	70.51
Disabled	921		921		
Skilled Nursing Facility					
Aged	259		259	267	1.89
Disabled	8		8		
Home Health Services					
Aged	123	$ 46	169	183	1.30
Disabled	9	5	14		
Physician Services					
Aged		2,805	2,805	3,026	21.43
Disabled		221	221		
Outpatient Services					
Aged		402	402	600	4.25
Disabled		198	198		
Other Services					
Aged		82	82	88	.62
Disabled		6	6		
Total Medicare	$10,353	$3,765	$14,118		100.00%

[a] Hospital Insurance.
[b] Supplementary Medical Insurance.

Source: U.S. Office of Management and Budget. The Budget of the United States Government, FY 1977, Appendix (Washington, D.C.: Government Printing Office, 1976), pp. 374-75.

Table VIII-2.

Medicaid Federal Expenditures in
Selected Areas, FY 1975
(in millions)

Service	Expenditures	% of Total $
Total, Medicaid	$12,028*	
Skilled Nursing Facilities	2,200	18.29
Intermediate Care Facilities	1,838	15.28
ICF-Mentally Retarded	362	3.01
Psychiatric Hospitals	600	4.99
Home Health	28	.23

*The federal share is $6,743 million.

Source: Medical Services Administration, Department of Health, Education, and Welfare.

Table VIII-3.

Expenditures: Gerontopia
Medicaid Program, FY 1979

Service	Expenditures	% of Total
Total	$ 336,696,553	
Inpatient Hospital	105,993,653	31.48
Skilled Nursing Facility Service	47,888,251	14.22
Intermediate Care Facility Services	89,962,569	26.72
Physician Services	28,219,943	8.38
Dental Services	11,303,240	3.36
Other Practitioners' Services	1,409,054	.42
Outpatient Hospital Services	11,213,663	3.33
Clinic Services	5,938,593	1.76
Laboratory & Radiological Services	1,623,420	.48
Home Health Services	736,127	.22
Prescribed Drugs	29,131,357	8.65
Family Planning Services	1,593,183	.47
Other Care	1,683,500	.50
		100.00%

Source: Division of Medical Assistance.

Federal law requires that any state participating in federal matching funds for medical assistance under Medicaid make services available to all those who receive Supplemental Security Income (SSI) or some form of special assistance. This mandatory group is referred to as "categorically needy". States may opt to extend coverage to persons deemed "medically needy", or having adequate income for usual purposes, but do not have additional resources and income to pay extraordinary medical bills (U.S. GAO, 1979).

The Federal, State and County governments play integral roles in the administration of the Medicaid program. Within the Department of Health and Human Services (DHHS), the Health Care Financing Administration (HCFA) has the primary responsibility for the overall administration. The Department of Human Resources is designated as the single State Medicaid agency for the state of Gerontopia; it has delegated responsibility for administration of the State's Medicaid program to the Division of Medical Assistance (DMA) (State Guide to Law and the Elderly).

Among other activities, the Division of Medical Assistance is responsible for: (a) developing policies and procedures to insure that the needy population of the state receive appropriate medical care; and (b) establishing rates of reimbursement, conducting audits of long term care facilities and insuring that contractors fulfill their agreements.

The Licensure and Certification Section of the Division of Facility Services is responsible for establishing and maintaining health standards for public and private institutions offering services to Medicaid recipients, and also for seeing that agencies and institutions meet the requirements for participation in Medicaid (in order to be licensed) (State Guide to Law and the Elderly).

The county departments of Social Services determine Medicaid eligibility. The fiscal agent for Medicaid claims processing is under contract with the Division of Medical Assistance. In addition to claims processing, this fiscal agent is responsible for monitoring quality and appropriateness of services which are provided (EDS Federal 1980).

Medicaid is the major provider of long term care funds which primarily cover institutional services. In Gerontopia, roughly 75% of nursing home expenses were financed by Medicaid and Medicare, with Medicare accounting for 15 percent and Medicaid accounting for 85 percent of the reimbursement from those two sources. Medicaid federal expenditures in selected areas of long-term care are shown for 1975 in Table XIII-2. Table XIII-3 shows the breakdown of Medicaid expenditures by service for the state of Gerontopia.

Private Insurance

Health and accident insurance policies are available to persons over 65 from private companies in Gerontopia to supplement the gaps in Medicare. The State Department of Insurance is available to provide information about policy terms and about license status of the agent.

Many older individuals purchase private health insurance to attempt to cover gaps in Medicare provision. Major items not covered by Medicare Part A and/or Part B consist of the following (U.S. Health Care Financing Administration, 1980):

Hospital Insurance	Medical Insurance
. More than 150 days of inpatient hospital care in a benefit period (over 90 days if you have used all your "lifetime reserve days).	. More than 100 home health visits in a calendar year.
. More than 100 days of inpatient skilled nursing facility care in a benefit period.	. Drugs and medicines you buy yourself.
. Nursing home care in other than a skilled nursing facility.	. Eyeglasses (except after cataract surgery).
. More than 100 home-health visits for a benefit period.	. Hearing aids.
. Private duty nursing.	. Dental Care
. Private room (unless medically necessary).	
. Care outside the Unites States.	
. Services and supplies that are not medically necessary.	

There are a variety of means of supplementary Medicare coverage through private insurance. The basic types include: continuation or conversion of pre-65 coverage; Medicare supplement policies; catastrophic or major medical expense; health maintenance organizations (HMO's); and limited coverage policies such as hospital indemnity, nursing home coverage, and specified disease coverage.

Distribution of Health Care Expenditures

In 1978, persons 65 and older in the United States paid for 36.8% of their health care expenditures, through their own funds or other private sources. This represents $746 of an average annual health care bill of $2,026. Medicare covered 44.1% of the expenditures, and the remaining costs were met through Medicaid (13.4%) or other public funds (5.7%) (Fisher, 1980).

Most older people must pay for all of their dental care expenses, as this area is not covered by Medicare. Even though physicians' services were covered to some extent by Medicare in 1978, individuals over 65 paid for 40% of these fees on the average. Drugs and medical appliances (including eye glasses) are covered minimally, if at all, by Medicare; private sources covered 84.4% and 66.9%, respectively of the costs of these items in 1978. In terms of institutional care, 87.5% of hospital expenses, but only 46.2% of nursing home costs, were covered by public funds (Fisher, 1980).

Per capita health expenditures in Gerontopia are lower on the average than national figures. In 1974, for example, national per capita health expenditures were estimated to be $559.96, compared to $463.29 in Gerontopia. Costs of institutional care and professional services were notably lower in Gerontopia than the nation as a whole, while drug expenditures and costs of public health activities were substantially higher in the state.

Health Care Programs and Providers

Private Medical Practice

Private medical practice is a major source of health care provision in the United States. Average number of visits per year increase as a function of age. For example, persons under 18 years of age in the United States made roughly 4,100 visits per thousand population in 1975-1976 compared to 4,700 visits for those 18-24 years old, 5,000 visits for persons age 25-44, 5,700 visits for 45-64 year old individuals and 6,700 visits per thousand for the elderly population. In 1977, older persons had a mean of 6.5 contacts per year with physicians outside of institutional settings. Almost three-fourths of these contacts took place in a physician's office, while roughly 10% took place in hospital out-patient departments, 10% were by telephone, and 5% of contacts consisted of home visits (U.S. Public Health Service, 1980).

The Veterans Administration

The Veteran's Administration (VA) is a major provider of health care for the elderly and disabled. It provides health care free of charge to veterans who were impaired during service or who are unable to afford medical care elsewhere. Four wars in this century have left the United States with 30 million former military personnel and their families (U.S. News and World Reports, June 1980). The average age of the largest group - those from World War II - is about 60 years of age.

The Veterans Administration maintains by far the largest hospital and health care system in the United States (U.S. News and World Reports, June 1980). The VA Hospital network has grown from 47 in 1930 to 172 in 1980. Hospitals are located in every state and treat more than 1.3 million patients per year. Nursing homes and domicilaries (boarding homes) now care for 78,000 veterans a year in 93 units which are connected with hospitals. Gerontopia has 4 VA hospitals, 2 with nursing home units.

Numerous long term care programs planned or in operation include home care programs, adult day care centers, new styles of domiciliary care, personal care group homes, and special programs for veterans with chronic diseases and psychosocial problems (U.S. News and World Report, 1980). The Veterans Administration is also undertaking the developing of Geriatric Research, Education, and Clinical Centers (GRECC) in order to integrate new approaches in geriatric care into the VA care plans.

Public Health

Each county health department in Gerontopia must offer certain services as mandated by the Division of Health Services in the Department of Human Resources; additional services are optional. Approximately half of the counties in Gerontopia offer a comprehensive range of adult screening services (e.g., blood pressure monitoring).

Anyone may receive these screening services without cost; however, if a physician prescribes a series of tests to some one who has medical insurance the health department may bill the insuror.

Home Health

Home Health Agencies offer nursing services and a range of therapeutic and supportive services to the elderly and disabled in their homes.

In 1980, Gerontopia had 85 home health agencies covering 98 out of 100 counties. Fifty-five of these agencies are health department based, 22 are voluntary non-profit, and 8 are proprietary. Total patients served by these agencies in FY 1978-1979 was 17,525 with 404,318 total visits for the same period of time (1980 Annual Home Health Report). More detailed figures for FY 77-78 are in Table XIII-4.

Selected Public Health Departments not maintaining adequate home health components were assisted to offer in-home services under PL 94-63, the Special Health Revenue Sharing Act of 1975.

Adult Day Care

Adult day care programs provide services in a group setting for persons who do not require 24-hour institutional care. Programs may provide restorative care for persons recovering from stroke or surgery, socialization for the mentally confused, supportive services for individuals in crisis, and assistance with activities of daily living. Any of the following services may be offered by a program: general nursing services, rehabilitative services, personal care services, nutrition services, social/recreational services, social work services, and transportation (Holmes and Holmes, 1979; Weiler and Rathbone-McCuan, 1978).

Adult day care programs have expanded in numbers from a few demonstration projects in the early 1970's to over 600 currently (planned or in operation) across the nation (Health Care Financing Administration, Personal Communication) Gerontopia had over 20 programs in operation in both urban in rural areas in 1978, and most were receiving funds from Title XX of the Social Security Act. (See the section on Social Services in Chapter VII for recent figures on clients served and total expenditures in Gerontopia.)

Table VIII-4.

HOME HEALTH SERVICES STATE SUMMARY
FY 1377-78

MSA	PATIENTS SERVED	Patient Visits: NURSE	AIDE	PT	OTHER	TOTAL VISITS
I	4,443	80,080 (18.0)[1]	16,938	13,426	7,796	118,240 (26.6)[2]
II	2,840	38,845 (13.7)	18,838	3,764	988	62,435 (22.0)
III	1,124	15,484 (13.8)	7,011	2,343	562	25,400 (22.6)
IV	2,413	29,676 (12.3)	8,542	3,884	1,148	43,250 (17.9)
V	2,086	27,480 (13.2)	7,123	5,135	779	40,517 (16.2)
VI	3,686	67,196 (18.2)	26,142	12,239	1,934	107,511 (29.2)
Total	16,592	258,761 (15.6)	84,594	40,791	13,207	397,353 (23.4)

Demographics

Unduplicated Patient Total - 16,592

Age - 71% of patients 65 years and older

Race - 66% White 33% Black 1% Other

Staffing (not full time equivalents)

Over 605 RN's working in home health.
" 60 LPN's "
" 152 Aides "
" 55 PT's "
" 18 ST's "
" 18 Orderlies "
" 4 OT's "
" 3 MSW's "

Charges & Payment Sources

Charge per visit - $26/nurse $18/aide
(excludes public provider figures)

Total reimbursement to our state's home health agencies exceeded $7 million.

Medicare 85.7% Medicaid 9.3%
Self Pay 1% Private Insurance 2%
Other 2%

Source

Department of Human Resources
Division of Health Services
Chronic Disease Branch
12/78.

[1] Average Nurse Visits Per Patient
[2] Average Total Visits Per Patient

Hospitals

Gerontopia has 165 hospitals with roughly 40,000 total beds. Of the total number of hospitals, 32 serve special populations such as veterans or persons in need of rehabilitation. Hospitals tend to be relatively small and widespread throughout the state (State Atlas).

Long-term Care Facilities

Long-term care institutions provide services such as rehabilitation, therapy, and maintenance-level care for persons with chronic physical or mental impairments. Table VIII-5 outlines the following variables utilized in the determination of statewide long-term care bed need for the years 1978-1985: service population, patient days, and annual utilization rate per 1,000 population. Projected average daily census and total bed need estimates are provided, along with annual inventories of beds expected to be available.

The figures noted in Table VIII-5 are primarily nursing home beds, but long-term care units of general hospitals and freestanding long-term care hospital beds (except rehabilitation and mental disease) are also included. However, family care homes and homes for the aged are also important long-term care facilities. According to the 1980 State Medical Facilities Plan, there were 271 homes for the aged in Gerontopia (roughly 10,000 beds) and 536 family care homes (approximately 2,500 beds).

Voluntary Resources

Organized citizens efforts which are coordinated by a central agency and supported through voluntary contributions enable a wide range of health-related services to be implemented. At least 15 such voluntary agencies in Gerontopia sponsor the following types of activities: maintenance of a community health information service; purchasing of drugs and medical equipment; operation of diagnostic clinics and support for free clinics; provision of nursing services and related home care needs; liaison with professional organizations; and provision of funds for training, research, and continuing education in health activities (State Atlas).

Table VIII-5.

LONG-TERM CARE BED NEED DETERMINATION:

STATE SUMMARY. (FY 1980)

Year of Proj.	Service Population 0-64	65-74	75+	Patient Days 0-64	65-74	75+	Total	Days/1000 Pop. Per Year Use Rate 0-64	65-74	75+	Proj. ADC	Bed Need	Existing Inventory	U/C	Adj. Inv.	Bed (Surplus) Deficit
1978	4,928,000	353,647	196,353	664,648	1,257,581	3,776,537	5,698,766	135	3,556	19,233			18,595	1,785	20,380	
1979	4,997,858	361,071	205,521	674,380	1,284,183	3,953,924	5,912,487						18,595			
Adjus.				22,813	45,506	157,470	225,789						1,020			
				697,193	1,329,689	4,111,394	6,138,276	139	3,683	20,005	16,818	18,687	19,615	765	20,380	(1,693)
1980	5,067,716	368,455	214,689	707,230	1,357,211	4,295,598	6,360,039						19,615			
Adjus.				17,935	35,016	116,555	169,506						275			
				725,165	1,392,227	4,412,153	6,529,545	143	3,779	20,551	17,889	19,877	19,890	490	20,380	(503)
1981	5,137,574	375,859	223,957	735,455	1,420,436	4,601,197	6,757,088						19,890			
Adjus.				12,505	27,021	97,897	137,423						490			
				747,960	1,447,457	4,699,094	6,894,511	146	3,851	20,991	18,889	20,989	20,380		20,380	609
1982	5,207,432	383,263	233,025	758,410	1,476,183	4,892,061	7,126,654									
Adjus.				4,388	10,056	39,211	53,655									
				762,798	1,486,239	4,931,272	7,180,309	146	3,878	21,162	19,673	21,857	20,380		20,380	1,477
1983	5,277,290	390,667	242,193	773,300	1,515,154	5,125,750	7,414,204	146	3,878	21,162	20,312	22,570	20,380		20,380	2,190
1984	5,347,148	398,071	251,361	783,803	1,544,071	5,320,226	7,648,100	146	3,878	21,162	20,954	23,281	20,380		20,380	2,901
1985	5,417,000	405,469	260,531	794,305	1,572,966	5,514,747	7,882,018	146	3,878	21,162	21,595	23,994	20,380		20,380	3,614

Scurce: State Medical Facilities Plan.

Chapter IX

MENTAL HEALTH PROGRAMS

Availability and funding of mental health services (such as psychiatric hospitals and community mental health centers) in Gerontopia are described. Figures on utilization of statewide mental health programs by elderly residents are also included.

Chapter IX

MENTAL HEALTH PROGRAMS

Mental health services encompass a diverse array of preventive, therapeutic and rehabilitative services (Koran, 1977). Services are offered in a variety of both public and private settings: in private practice; in outpatient psychiatric clinics; in state and county mental hospitals; in community mental health centers; in psychiatric halfway houses; and in nursing and personal care homes (Koran, 1977).

The Gerontopia Division of Mental Health is one of several divisions of the Department of Human Resources. The Division provides services to the mentally ill, the mentally retarded, and alcoholic and drug abusing citizens through a service delivery system composed of community mental health centers supported by regional psychiatric hospitals, alcoholism rehabilitation centers and mental retardation centers. All one hundred counties have access to a community mental health center. The state supports four psychiatric hospitals, five mental retardation centers, three alcoholic rehabilitation centers, one school for the emotionally disturbed and one special care center. Four Regional Offices for the Gerontopia Division of Mental Health Services are distributed geographically across the state. In addition, numerous private practices offer mental health services across the state, particularly in the more urban areas.

Various means are used to finance mental health services. Private insurance coverage for mental disorders is less widespread than for somatic illnesses. In 1970 the Social Security Administration estimated that some 80% of the civilian population had some private health insurance coverage for hospital care for general illness while only 63% had similar coverage for mental disorders. Corresponding rates for physician visits both in hospitals and in offices were also lower for mental disorders than for general illnesses (Koran, 1977).

Medicare benefits include inpatient treatment in a psychiatric hospital limited to 190 days in a lifetime, under Part A (hospital insurance). Under Part B (supplementary medical insurance), benefits for physican's outpatient care for mental illness is limited to 50 percent of the charges, or $250, whichever is less. Physician visits for inpatient care are not limited, while home visits to be provided by mental health agencies are limited to one (Social Security Administration, 1980). Koran (1977) reports that mental health care accounts for a surprisingly small percentage of Medicare hospital expenditures. Though Medicaid mental health benefits vary from state to state, the federal government has long viewed mental health problems the state's responsibility through its own state hospital (Koran, 1977).

Table IX-1 shows that numbers of older people using mental health services in Gerontopia almost doubled between 1967-68 and 1977-78, with community clinics utilization providing a greater share of the increase in utilization. During the ten-year period reported, admissions to mental hospitals among persons 65 and older actually declined. While this may be related to increased use of outpatient care, it may also be associated with the rise in utilization of long-term care facilities (Pollak and Hilferty, 1976).

Community mental health centers are an important link in the continuum needed for comprehensive care. Table IX-2 shows admissions to community health centers for persons 65 years and older for FY 1970 and FY 1973-1979 in Gerontopia. Admissions in 1979 for persons 65+ numbered 2,978 and of these 840 were alcohol admissions.

Table IX-1.

AGE GROUPINGS OF ADMISSIONS[a] TO STATE MENTAL HEALTH FACILITIES FISCAL YEARS ENDING 1968 - 1978

Fiscal Year	Total All Facilities	Facilities			
		Hospitals	ARC's[b]	Clinics[c]	MR Centers[d]
		Total All Ages			
1967-68	32,849	14,154	597	17,578	520
1968-69	35,856	14,217	761	20,238	640
1969-70	44,843	14,309	2,642	27,347	545
1970-71	50,564	14,489	2,834	32,812	429
1971-72	53,957	14,313	2,890	36,288	466
1972-73	58,684	13,976	3,233	41,082	393
1973-74	66,095	16,537	4,480	44,715	363
1974-75	81,830	17,382	5,977	58,127	344
1975-76	89,258	16,524	5,791	66,657	286
1976-77	90,181	15,896	5,400	68,695	190
1977-78	93,193	14,888	5,720	72,548	237
		17 yrs. and Under			
1967-68	5,920	357	-	5,118	445
1968-69	6,889	371	-	5,940	578
1969-70	8,985	436	-	8,054	495
1970-71	10,028	515	-	9,143	370
1971-72	11,360	433	-	10,526	401
1972-73	11,575	451	1	10,783	340
1973-74	13,471	519	52	12,586	314
1974-75	14,885	654	48	13,903	280
1975-76	16,337	706	3	15,408	220
1976-77	15,844	719	5	14,987	133
1977-78	16,937	641	11	16,107	176
		18-44 yrs.			
1967-68	18,760	7,372	338	8,978	72
1968-69	21,275	7,646	190	10,181	58
1969-70	22,611	7,716	1,360	13,466	49
1970-71	26,453	7,846	1,443	17,110	54
1971-72	27,768	7,860	1,445	18,402	61
1972-73	30,583	7,567	1,664	21,301	51
1973-74	34,519	9,157	2,187	23,131	44
1974-75	43,587	9,709	3,044	30,777	57
1975-76	47,585	9,234	2,968	35,322	61
1976-77	49,170	9,135	2,859	37,121	55
1977-78	51,451	8,614	3,050	39,729	58
		45-64 yrs.			
1967-68	8,205	4,955	253	2,994	3
1968-69	8,777	4,886	357	3,530	4
1969-70	10,956	4,822	1,223	4,911	-
1970-71	11,714	4,822	1,329	5,558	5
1971-72	12,439	4,819	1,357	6,259	4
1972-73	13,960	4,787	1,486	7,685	2
1973-74	15,359	5,653	2,083	7,618	5
1974-75	20,032	5,766	2,693	11,566	7
1975-76	21,670	5,413	2,624	13,628	5
1976-77	21,229	4,856	2,323	14,050	2
1977-78	21,083	4,488	2,457	14,135	3
		65 yrs. and Over			
1967-68	1,964	1,470	6	488	-
1968-69	1,915	1,314	14	587	-
1969-70	2,291	1,315	59	916	1
1970-71	2,369	1,306	62	1,001	-
1971-72	2,390	1,201	88	1,101	-
1972-73	2,566	1,171	82	1,313	-
1973-74	2,746	1,208	158	1,380	-
1974-75	3,326	1,253	192	1,881	-
1975-76	3,666	1,171	196	2,299	-
1976-77	3,938	1,188	213	2,537	-
1977-78	3,922	1,141	202	2,577	-

a/ First admissions plus re-admissions.
b/ Alcoholic Rehabilitation Centers.
c/ Mental Health Clinics and Centers.
d/ Mental Retardation Centers.

SOURCE: Department of Human Resources, Division of Mental Health, Management Information System-Statistics.

Table IX-2.

ADMISSIONS AND ACTIVE CASELOAD TO COMMUNITY MENTAL HEALTH CENTERS

FY70 AND FY73-79

	FY70	FY73	FY74	FY75	FY76	FY77	FY78	FY79
Admissions Referred by Psychiatric Hospital	3,659	3,010	887	2,267	2,046	2,075	2,149	2,002
Admissions Total	28,357	41,898	44,734	58,439	66,037	68,042	71,838	77,305
Admissions 65 & Over	973	1,324	1,361	1,892	2,159	2,420	2,459	2,978
Alcohol Admissions Total	1,644	6,336	6,777	15,067	18,661	21,526	22,392	24,893
Alcohol Admissions 65 & Over	45	138	156	483	501	690	621	840
Active Cases - Total	N/A	N/A	N/A	64,206	73,212	72,564	73,174	77,909
Active Cases - 65+	N/A	N/A	N/A	2,826	3,384	3,704	4,005	4,662

Source: State Division of Mental Health

Chapter X

VOLUNTEER SERVICES

Roles served by volunteers are discussed. Both volunteer services for older people and the role of the elderly as volunteers are noted.

Chapter X

VOLUNTEER SERVICES

Though the appearance and organization of volunteer services varies greatly across the United States, volunteer or unpaid services have historically played an important role in the delivery of health care and social services to the elderly. The value of this service has unfortunately been overlooked in recent years as attention increasingly focused upon the technology of medical care and the professional credentials that accompany such care (Somers, 1980).

There is reason to rediscover the value of volunteer services, particularly to provide assistance to the expanding elderly population whose needs often arise out of functional disabilities and struggles with activities of daily life rather than needs requiring high technology medicine.

A variety of volunteer initiatives can be found in Gerontopia. Perhaps the greatest volunteer efforts are informal, and have no group affiliations but become visable as the need arises. This sort of natural supporting network is often typical of more rural areas, and thus is likely to be found in Gerontopia, which has a substantial rural population (State Guide to Volunteer Programs for the Elderly).

More formal volunteer services often develop through organizations which may operate totally with unpaid assistance from community members. These organizations may sponsor related activities, community clubs, or local units of larger volunteer organizations, such as the American Cancer Society.

Some volunteer activities are perhaps more complex and far reaching, and operate with the benefit of organizational affiliation plus paid professional leadership. In Gerontopia, the Department of Human Resources lends professional and funding support to volunteer programs for the elderly such as Telephone Reassurance, Friendly Visitors, the Senior Advocate Program, and Natural Helpers (State Guide to Volunteer Programs for the Elderly).

Another kind of volunteer service not to be overlooked is that where the elderly person is the volunteer serving his/her community with talents gained over many years of experience. Some national programs are organized through ACTION and include such programs as Foster Grandparents and Retired Senior Volunteers (RSVP). (Gelfand and Olsen, 1980) Other opportunities exist on a community basis for senior citizens to volunteer to serve their communities.

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APPENDIX A.

ILLUSTRATIVE LIST OF PROGRAM INITIATIVES

The following projects exemplify attempts to restructure existing service provision or to implement new concepts to enhance the well-being of older persons.

Most projects involve one or more of the following: innovative options for community-based care; local or statewide integration of services; employment opportunties or financial relief; and advocacy/ self-help among older persons. A brief description and one or more references are presented following the title of the project or concept. A number of the abstracts (marked by an asterisk) were adapted from O'Brien, J.E. and Whitelaw, N. Planning options for the elderly. Portland State University, Institute on Aging, School of Urban Affairs, 1978.

ACCESS PROJECT

The ACCESS Project was designed to demonstrate alternative approaches to delivering and financing long term care to the adult disabled and elderly population of Monroe County, New York. It provides a single-entry system aimed at improving quality and controlling costs. A case-management team assesses individuals' needs, recommends community-service or institutional-placement alternatives, and assures continuity of care through on-going case management.

Eggert, G.M.; Bowlyow, J.E., and Nichols, C.W. Gaining control of the long term care system: first returns from the ACCESS experiment. The Gerontologist, 1980, 20(3, Part I), 356-363.

AID TO FAMILIES WITH DEPENDENT PARENTS*

In order to encourage families to care for their aged dependent parents in their home, various kinds of incentives could be employed. Additional federal tax deductions for dependent parents could be granted or a small monthly stipend could be provided to the family to assist in the purchase of food, medication, etc. Low interest loans could be awarded for remodeling or adding to the family's home to provide the extra space required to have the aged parent live with the family. If the elderly person had no relatives, or if he or she preferred, these programs could be made available to a friend willing to care for the dependent individual.

Atelsek, F. Alternatives to institutional care. The American University Development Education and Training Research Institute, Washington, DC, August, 1972, Vol. II, 3-63.

ALTERNATIVE HEALTH SERVICES PROJECT

This Title XIX demonstration project implemented in Georgia provides a comprehensive system of community care services to Medicaid eligible clients. Services include 1) alternative living services such as 24 hour residential services, 2) adult day rehabilitation and 3) home delivered services such as physical therapy and home health aides.

Skellie, F.A. The impact of alternatives to nursing home care. Journal of the American Health Care Association, 1979, 5(3), 46-53.

Skellie, F.A. and Coan, R.E. Community based long-term care and mortality; Preliminary experimental findings. Gerontologist, 1980, 20(3), 372-379.

CENTERCARE--COMMUNITY SUPPORT SERVICES TO THE INSTITUTIONALIZED AGED

In an attempt to meet the human needs of nursing home patients, one multi-purpose senior center in Baltimore, MD. recruits them to participate in senior-center activity programs designed to serve noninstitutionalized older people. Volunteers aid in transporting the residents to the center and provide a welcoming environment.

Hirsch, C.S. Integrating the nursing home resident into a senior citizens center. The Gerontologist, 1977, 17(3), 227-234.

CHELSEA-VILLAGE HOME-CARE PROGRAM

The Chelsea-Village Program is a hospital-based home health program carried out by St. Vincent's Hospital in New York City. Patients are cared for effectively and efficiently due to regular participation by a physician, who has quick access to specialists and in-patient services when needed.

Brickner, P. and Scharer, L.K. Hospital provides home care for elderly at one-half nursing home cost. Forum, 1977, 1(2), 6-12.

COMMUNITY WORKSHOP*

The community workshop would be for retired employees of various local firms, both industrial and commercial. These retired individuals could form their own company, manufacture and market their own product. Space, equipment and other materials would be donated by local firms. In the United Kingdom programs such as this exist for retired employees of single firms, sponsored by former employees.

Nusberg, C. Foreign trends and innovations in service to the aging. International Federation on Aging, 1909 K Street NW, Washington, DC 20049.

CO-OPERATIVE HOUSING

Co-operative housing, or co-ops, involves a low-cost, joint living arrangement of a number of individuals or couples in which each family unit would have a bedroom, but members would share in common other areas of the house and would share activities such as cooking, cleaning, eating, maintenance, and paying bills. It is based on the same concept as food co-ops, farm supply co-ops,etc. A non-profit cooperative could be formed to act as a trustee of the designated house. The property values of the homes owned by members would be condensed to form the trust, and the trust in turn would issue securities to former homeowners for the appraised value of each house involved. Family units would contribute to the trust on a monthly basis to cover maintenance, taxes, insurance, etc. The trust pays interest annually to people holding securities plus enough money to pay off the original members' investment.

Buchele, C. Co-ops in the sunset days. Co-op Magazine, Jan./Feb., 1980, Box 7293, Ann Arbor, MI 48107

COOPERATIVE SOCIAL SERVICES ARRANGEMENT

A rural nursing home and the social work department of a nearby college formed a mutually beneficial arrangement. In their contractual agreement, social work consultation was provided to the nursing home by the college's social work faculty, who would in turn use the home as a field placement or training ground for undergraduate students majoring in social work.

Whittington, R. Social services for a nursing home: a collaborative approach. Health and Social Work, 1977 2(3), 170-178.

DEFERRED PROPERTY TAXES*

In order to prevent the loss of homes by elderly persons to inability to pay increasing property taxes, a solution would be permit those of retirement age to defer payment of all or part of their property taxes until after death. The program could be open to all elderly over 60 with no minimum or maximum income requirements, or it could be limited to those with low incomes. The deferred taxes, plus an interest charge, would be due within one year after the property owner's death. A surviving spouse over 60 could continue the deferral.

Davies, J. Elderly offered option to defer property taxes until their death. Statesman/Journal, Salem, Oregon, Sunday, July 18, 1976.

FRIENDSHIP CENTER: COMMUNITY SUPPORT FOR THE FRAIL ELDERLY

This program is designed to provide social and health-related support services such as counseling, health screening, and home visits to non-institutionalized frail elderly. The Friendship Center was initiated as a model service project in New York City, and could be adapted to other locales.

Sanier, J; Ochs, S. and McGloin, J.M. Reaching and serving the mentally frail elderly. Aging, 1979, 293-294, 10-14

GRANNY FLATS*

Currently in use in Australia, granny flats are prefabricated units which can be erected in the backyards of established homes, connected to sewerage, water, and electrical supply, and easily dismantled and removed. These units would allow an older person to maintain his or her independence while having a greater amount of security because of the proximity of family or friends.

Nusberg, C. Foreign trends and innovations in service to the aging (Appendix, p. 10). International Federation on Aging, 1909 K Street NW, Washington, DC 20049.

HOME AIDE EXTENSION PROGRAM

In an attempt to meet the service needs of poor elderly excluded from receiving home-aide service due to eligibility requirements and service restrictions, a cooperative program evolved among three agencies. In this program, entitled the Home Aide Extension Program, the Benjamin Rose Institute provides home aides to the Visiting Nurse Association and the Chronic Illness Center in return for supervision of home aides by their professional social workers.

Noelker, Linda and Zev Harel. Aged excluded from home health care. An interorganizational solution. The Gerontologist, 1978, 18(1), 37-41.

MEDICARE BENEFICIARY AIDE SERVICES

This HCFA-sponsored program trains volunteers to assist Medicare beneficiaries with the "red-tape" of Medicare reimbursement, in the event that it is necessary that beneficiaries themselves file for reimbursement. The training program can be initiated by any non-profit volunteer organization, which contacts HCFA to set up a two-to-four day training program.

Blanchard, J. A. Medicare beneficiary services and information programs. In Perspectives on Medicaid and Medicare Management, Baltimore, MD: Department of Health, Education and Welfare, Health Care Financing Administration, February 1980, pp. 25-29. Publication No (HCFA) 80-20021.

NEIGHBOR-AIDE*

A neighbor-aide would be older person selected by neighborhood residents and employed to perform such tasks as watching out for strangers in the neighborhood, keeping an eye on houses when the owners are out of town, caring for plants and pets, being available to help or get help in an emergency, looking in on persons who are sick or disabled or living alone, and walking children to school. As neighbor-aides, older people would perform useful tasks for the community while earning additional income.

Atelsek, F. et al. Alternatives to long-term institutional care. The American University Development Education and Training Research Institute, Washington, DC, August, 1972, Vol. I, 11-131.

NURSING HOME GRIEVANCE OFFICES*

Should the resident advisory committee be unable or unwilling to assist a particular resident in solving a problem or if the resident is afraid to take the problem to the committee, a complaint office independent of the nursing home would be available to individual residents or their advocates. This office would be similar to the nursing home ombudsman project which has been demonstrated in a few states, but would be a local rather than a state office. Funds for its operation could possibly come from a tax on all nursing homes and other long-term care facilities in the area.

NURSING HOME WITHOUT WALLS

In the state of New York, a unique home health care plan allows authorized nursing home facilities and hospitals as well as home health agencies to provide reimbursed health care to people in their own homes. Due to the increased cost of facility development, it was felt that, rather than meet the increasing demand for long term care through construction of more nursing homes, available funds could be used to provide non-institutional patient care.

Jacobs, M. Nursing home without walls. American Health Care Association Journal, 1979, 5(1), 29-32.

RENT-A-GRANDPARENT*

Rent-a-Grandparent program would be similar to a temporary employment agency, where the individual or organizations desiring employment assistance contacts the agency, describes the job to be filled, the approximate starting and completing time, and a salary estimate. The agency then contacts an employee having the necessary skills, who may accept or reject the assignment. The Rent-a-Grandparent program could encompass elderly persons having a wide range of skills and of differential health and mobility states, as some work could be done in their own homes. Employment agencies already in existence could set up a component for older workers, or new, non-profit organizations could be established to perform the task of matching employment needs in the available skills.

Rent-a-Grandparent Program, Lambert House, 5120 SE 28th, Portland, OR

RESPITE CARE*

Respite care could be provided in a number of settings by various individuals, depending on the degree of care required by the older person. A neighborhood block home could serve as a respite care center for more capable, healthy elderly individuals who might benefit from a change of setting. For the elderly requiring a higher level of care, homes for the aged or nursing homes could have special short-term respite care wards, or private nurses or aides could be hired to stay in the home with the aged individual for a short period of time. If families who were caring for their aged parents could be identified to one another, arrangements could be made from various families to team up and allow one day off a week for each family.

Onlok Senior Health Services, 1490 Mason Street, San Francisco, CA 94133.

Robertson, Duncan R.; Amos Griffiths and Lionel Z. Cosin. A community-based continuing care program for the elderly disabled. Journal of Gerontology, 1977, 32(3), 334-339.

SELF-ADVOCACY*

In addition to supplying lobbyists information on matters crucial to the aged, self-advocacy organizations could raise the awareness of the elderly substantially by a campaign in three areas: (1) encouraging the aged to become members of advocacy organizations, (2) developing self-advocacy training packages, and (3) providing a list of agencies and organizations which serve advocacy needs of the elderly, accompanied by a brief description of what they do and how the elderly can contact the the local office. Another component of self-advocacy is to encourage the elderly to discover and exercise their legal rights. A Senior Citizen's Advocate position should be created whose office would respond to all inquiries from the aged about legal matters.

Advocacy in the field of aging. Available from the National Council on the Aging, 1828 L Street, NW, Washington, DC 20036

SELF-CARE/SELF-HELP PROGRAMS

A variety of new programs of this type encourage the elderly health-care consumer to take a more active role in maintaining or improving the state of his or her health. One self-care program designed specifically for the elderly is Georgetown University's Activated Patient program, for the Medicare population. Another self-help health group for older people is SAGE, an acronym for Senior Actualization and Growth Exploration. Widow outreach programs are another aspect of the self-help movement.

Butler, R. N.; Gratment, J.S.; Oberlander, D.L. and Schindler, L., Self-care, self-help, and the elderly. International Journal of Aging and Human Development, 1979-80, 10(1), 95-117.

SUPPORTIVE SERVICES PROGRAM FOR HOSPITALIZED ELDERLY RETURNING TO THE COMMUNITY

Older adults discharged from long hospital stays may need help in readjusting to community living. One model for such help, implemented in the University of Notre Dame's Mental Health Outreach Program for the Elderly, involves the use of coordinated social casework to construct networks of formal and informal supports. Contact with the client is maintained before, during and after transfer.

Hubbard, Richard W.; John F. Santos and Marianne Wiova. A community-based model for discharge planning and aftercare for hospitalized older adults. Journal of Gerontological Social Work, 1978, 1(1), 63-68.

TRIAGE: A SINGLE ENTRY HEALTH CARE SYSTEM

The Triage Project, which operates in central Connecticut, is a model for single entry into a full spectrum of health, social, and life-support services. Central to the model is the provision of humane and cost-effective long-term care, which would allow the older person to remain at home whenever possible and prevent inappropriate institutionalization. Triage provides patient assessment, and a case management system which functions as an interface between client and multiple service agencies.

Quinn, J.L. Triage: coordinated care for the elderly. Journal of Continuing Education in Nursing, 1979, 10(4), 50-57.

WELL-ELDERLY CLINICS*

These clinics could be set up permanently, or they could function as mobile units much like x-ray and TB testing services, or they could function through elements of both, i.e. a mobile unit which is dispatched from a permanent center. The elderly would be examined by teams of health care professionals, given advice on prevention of disease and also treated for illness. They would be advised on oral hygiene, regular nourishment, therapeutic physical training, etc.

Revutskaya, R.G. The Union of Soviet Socialist Republics. In J.C. Brocklehurst (Ed.), Geriatric care in advanced societies. Baltimore: University Park Press, 1975.

APPENDIX B

ORGANIZATIONAL RESOURCES

I. Governmental Agencies

A. The Administration on Aging was established by the Older Americans Act in 1965. The Act has been amended several times with the most recent amendment in 1978. The Act lists federal objectives for older people and authorizes funding for the following programs:

.State and Community Grants Program
.Nutrition Program for the Elderly
.Model Projects Program
.Research and Development Program
.Manpower Development Program

The Administration on Aging serves as a federal funding source as well as a resource for state planning and advocacy for older people. The AoA decentralizes through ten regional offices, which are located within the Department of Health and Human Services Regional Offices. The main address of the Administration on Aging is 330 Independence Ave. SW, Washington, DC 20201.

B. Each State has a Division on Aging; in Gerontopia the Division on Aging is within the Department of Human Resources.

C. Area Agencies on Aging are the resources at the sub-state regional levels for planning and advocacy for older people. An Area Plan is submitted to the State Division of Aging annually, which 1) identifies needs 2) inventories resources, 3) sets objectives and, 4) funds services.

The Area Agency on Aging also provides information to the public, technical assistance, to local agencies and citizens groups, and helps to pool available resources through joint working agreements and memorandums of understanding. There are fifteen AAA's, one based in each council of Government (COG).

D. Health Planning under the National Health Planning and Resources Development Act of 1974, (P.L. 93-641) (As amended in 1979) is administered by the Bureau of Health Planning in the Health Resources Administration of the Department of Health and Human Services. Bureau headquarters are located in the Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852.

D. (continued)
DHHS Regional Offices liaise with state and local agencies in matters of health planning. The regional offices for DHHS are the same as regions for AoA.

E. The Statewide Health Coordinating Council (SHCC) is a forty-member council which is broadly representative of the population of the state. Its main responsibility is the development and preliminary approval of the State Health Plan. Final approval is given by the Governor.

F. The State Health Planning and Development Agency (SHPDA) assists the SHCC in developing the state plan by submitting a preliminary state health plan for consideration. The Department of Human Resources has been designated the SHPDA by the governor in Gerontopia. The Department also implements the important state's Certificate of Need Law.

G. Six Regional Health Systems Agencies (HSA's) in Gerontopia develop regional Health Systems Plans on which the State Health Plan is based. These agencies are private, non-profit organizations designated under federal law (P.L. 93-641) to conduct health planning activities at an areawide level. There are six Health Systems Agencies in the state of Gerontopia.

H. The Health Care Financing Administration within the Department of Health and Human Services administers the Medicare program, and on a federal level, the Medicaid Program.

I. The Department of Housing and Urban Development is responsible for funding and administration of federal housing programs.

J. The Veterans Administration provides medical and health care services to veterans in the United States. It also provides opportunities for clinical training and research.

II. Professional Organizations

Many organizations operate to represent the various professionals and service agencies who serve the elderly. Here is a listing of some of the agencies more relevant to the aged (which is by no means complete).

AMERICAN ASSOCIATION OF HOMES FOR THE AGING
1050 17th Street, N.W.
Suite 770
Washington, D.C. 20036

AMERICAN ASSOCIATION OF PSROs
11325 Seven Locks Road
Potomac, MD 20854

AMERICAN ASSOCIATION FOR REHABILITATION THERAPY, INC.
PO Box 93
North Little Rock, AR 72116

AMERICAN COLLEGE OF NURSING HOME ADMINISTRATORS
4650 East-West Highway
Washington, DC 20014

AMERICAN DENTAL ASSOCIATION
211 E. Chicago Ave.
Chicago, IL 60611

AMERICAN HEALTH CARE ASSOCIATION
1200 15th Street, NW
Washington, DC 20005

AMERICAN HEALTH PLANNING ASSOCIATION
1601 Connecticut Avenue NW, Suite 700
Washington, DC 20009

AMERCIAN HOSPITAL ASSOCIATION
840 N. Lake Shore Drive
Chicago, IL 60611

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Washington, DC 20005

AMERICAN NURSING HOME ASSOCIATION
1025 Connecticut Ave. N.W.
Suite 607
Washington, DC 20036

AMERICAN PHYSICAL THERAPY ASSOCIATION
1156 15th Street, NW
Washington, DC 20005

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 15th Street, NW
Washington, DC 20005

AMERICAN NURSES' ASSOCIATION
2420 Pershing Road
Kansas City, MO 64108

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
6000 Executive Boulevard
Rockville, MD 20852

AMERICAN SOCIETY FOR GERIATRIC DENTISTRY
431 Oaksdale Ave.
Chicago, IL 60657

BLUE CROSS AND BLUE SHIELD ASSOCIATIONS
840 North Lake Shore Drive
Chicago, IL 60611

COUNCIL OF STATE ADMINISTRATORS OF REHABILITATION
1522 K Street NW, Suite 610
Washington, DC 20005

HEALTH INSURANCE ASSOCIATION OF AMERICA
1701 K Street, NW
Washington, DC 20006

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
1625 Eye Street, NW Suite 420
Washington, DC 20006

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES
426 C Street, NE
Washington DC 20002

NATIONAL ASSOCIATION OF PHYSICAL THERAPISTS, INC.
PO Box 367
West Covina, CA 91793

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
5530 Wisconsin Avenue, Suite 955
Washington, DC 20015

NATIONAL ASSOCIATION OF SOCIAL WORKERS
1425 H Street, NW, Suite 600
Washington, DC 20005

NATIONAL ASSOCIATION OF STATE UNITS ON AGING
West Virginia Commission on Aging
State Capitol
Charleston, WV 25305

NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.
67 Irving Place
New York, NY 10003

NATIONAL LICENSED PRACTICAL NURSES ASSOCIATION
250 West 57th Street
New York, NY 10019

NATIONAL LEAGUE FOR NURSING
10 Columbus Circle
New York, NY 10019

U.S. CONFERENCE OF CITY HEALTH OFFICERS
1620 Eye Street, NW
Washington, DC 20006

III. Other Organizations and Associations Serving the Elderly.

Many other organizations serve the elderly in various roles such as consumer protection, advocacy, research, dissemination of information, referral, and as resources for guidance or for literature. Some are professionally oriented, others are volunteer in nature, and many are a mixture of both professionals and volunteers. Here is a listing of many of the more visable groups.

ACTION
806 Connecticut Avenue, NW
Washington, DC 20525

ACTION FOR INDEPENDENT MATURITY
1909 K Street, NW
Washington, DC 20006

ADMINISTRATION ON AGING
Department of Health, Education and Welfare
330 Independence Avenue, SW
Washington, DC 20201

ADULT EDUCATION ASSOCIATION OF THE U.S.A.
810 18TH Street, NW
Washington, DC 20006

ADVISORY COUNCIL ON PENSION AND WELFARE BENEFIT PROGRAMS
3RD Street and Constitution Ave, NW
Washington, DC 00210

AGING RESEARCH INSTITUTE
342 Madison Avenue
New York, NY 10017

ALTRUSA INTERNATIONAL, INC.
332 S. Michigan Avenue
Chicago, IL 60604

AARP (AMERICAN ASSOCIAITON OF RETIRED PERSONS) and
NRTA (NATIONAL RETIRED TEACHERS ASSOCIATION)
1225 Connecticut Avenue, NW
Washington, DC 20036

AFL-CIO DEPARTMENT OF COMMUNITY SERVICES
815-16th Street, NW
Washington, DC 20006

AMERICAN CANCER SOCIETY
777 Third Avenue
New York, New York 10017

AMERICAN DIABETES ASSOCIATION
One West 48th Street
New York, NY 10020

AMERICAN FOUNDATION FOR THE BLIND, INC.
15 West 16th Street
New York, NY 10011

AMERICAN GERIATRICS SOCIETY
10 Columbus Circle
New York, NY 10019

AMERICAN HEART ASSOCIATION
7320 Greenville Avenue
Dallas, TX 75231

AMERICAN LUNG ASSOCIATION
1740 Broadway
New York, NY 10019

AMERICAN PUBLIC WELFARE ASSOCIATION
1313 East 60th Street
Chicago, IL 60637

AMERICAN HEALTH FOUNDATION
320 East 43rd Street,
New York, NY 10018

AMERICAN MENTAL HEALTH FOUNDATION, INC.
2 East 86th Street
New York, NY 10028

AMERICAN RED CROSS
17th and D Streets, NW
Washington, DC 20006

ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION
1835 K STREET, NW
Washington, DC 20006

ASSOCIATION FOR THE ADVANCEMENT OF AGING RESEARCH
c/o Dr. Bernard Strehler, Exec. Chairman
Molecular Biology Department
ALBR, Room 126
Los Angeles,CA 90007

THE ASSOCIATION OF JUNIOR LEAGUES, INC.
825 Third Avenue
New York, NY 10022

ASSOCIATION OF PRIVATE PENSIONS AND WELFARE PLANS
1028 Connecticut Avenue, NW
Washington, DC 20036

ARTHRITIS FOUNDATION
3400 Peachtree Road, NE
Atlanta, GA 30326

ARTHRITIS SOCIETY
920 Yonge Street, Suite 420
Toronto, Canada M4W 3J7

CANCER CARE, INC. & NATIONAL CANCER FOUNDATION, INC.
One Park Avenue
New York, NY 10016

CITIZENS FOR BETTER CARE IN NURSING HOMES, HOMES FOR THE
THE AGED AND OTHER AFTERCARE FACILITIES, INC.
163 Madison Avenue
Detroit, MI 48202

CLEARINGHOUSE ON EMPLOYMENT FOR THE AGING
80 Reid Avenue
Port Washington, NY 11050

COALITION OF NATIONAL VOLUNTARY ORGANIZATIONS
1214 16th Street, NW
Washington, DC 20036

COMMITTEE FOR NATIONAL HEALTH INSURANCE
821 15th Street, NW, Suite 801
Washington, DC 20005

COMMUNITY HEALTH ADVOCACY NETWORK
231 Oakland Avenue
Pittsburgh, PA 15213

COMMUNITY SERVICES ADMINISTRATION
Office of Program Development
1200 19th Street, NW
Washinton, DC 20506

CONCERNED SENIORS FOR BETTER GOVERNMENT
1346 Connecticut Avenue, NW
Room 1213
Washington, DC 20036

EDUCATION NETWORK FOR OLDER ADULTS
36 S. Wabash, Suite 714
Chicago, IL 60603

EUTHANASIA EDUCATIONAL COUNCIL
250 W. 57th Street
New York, NY 10017

FEDERAL BUREAU OF LABOR STATISTICS
14th Street & Constitution Ave., N.W.
Washington, DC 20201

GERONTOLOGICAL SOCIETY OF AMERICA
1835 K Street, NW, Suite 305
Washington, DC 20006

GOODWILL INDUSTRIES OF AMERICA, INC.
9200 Wisconsin Avenue
Washington, DC 20014

GRAY PANTHERS
3635 Chestnut Street
Philadelphia, PA 19104

INSTITUTE FOR RETIREMENT STUDIES
7040 Crawford Hall
Case Western Reserve University
Cleveland, OH 44106

INTERNATIONAL FEDERATION OF AGING
1909 K Street, NW
Washington, DC 20006

INTERNATIONAL SENIOR CITIZENS ASSOCIATION, INC.
11753 Wilshire Blvd.
Los Angeles, CA 90025

KIWANIS INTERNATIONAL
101 E. Erie Street
Chicago, IL 60611

LABOR DEPARTMENT
Office of Pension Welfare Benefit Programs
3rd Street and Constitution Ave., NW
Washington, DC 20210

LEGISLATIVE COUNCIL FOR OLDER AMERICANS, INC.
110 Arlington Street
Boston, MA 02116

LEGAL SERVICES FOR THE ELDERLY
2095 Broadway
New York, NY 10023

MEDIC ALERT FOUNDATION INTERNATIONAL
PO Box 1009
Turlock, CA 95380

MENTAL HEALTH ASSOCIATION, NATIONAL HEADQUARTERS
1800 North Kent Street
Arlington, VA 22209

NATIONAL ALLIANCE FOR SENIOR CITIZENS, INC.
PO Box 29031
Washington, DC 20036

THE NATIONAL ASSEMBLY OF NATIONAL VOLUNTARY HEALTH AND SOCIAL WELFARE ORGANIZATIONS, INC.
291 Broadway
New York, NY 10007

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING, INC.
1828 L. Street, NW
Washington, DC 20036

NATIONAL ASSOCIATION OF HUMANISTIC GERONTOLOGY
41 Tunnel Road
Berkeley, CA 94705

NATIONAL ASSOCIATION OF OLDER AMERICANS
12 Electric Street
West Alexandria, OH 45381

NATIONAL ASSOCIATION OF THE PHYSICALLY HANDICAPPED, INC.
76 Elm Street
London, OH 43140

THE NATIONAL CAUCUS ON THE BLACK AGED, INC.
1730 M STREET, NW
Suite 811
Washington, DC 20036

NATIONAL CENTER FOR VOLUNTARY ACTION
1785 Massachusetts Ave. NW
Washington, DC 20036

NATIONAL CLEARING HOUSE ON AGING
Dept. of Health, Education and Welfare
400 Sixth Street, SW
Washington, DC 20201

NATIONAL CONFERENCE ON SOCIAL WELFARE
22 West Gay Street
Columbus, OH 43215

225 Park Avenue, SO., 7th Floor
New York, NY 10003

NATIONAL COUNCIL OF SENIOR CITIZENS
1511 K Street, NW
Washington, DC 20036

NATIONAL COUNCIL ON THE AGING
1828 L Street, NW
Suite 504
Washington, DC 20036

NATIONAL COUNCIL ON THE AGING

Regional Offices

NORTHEAST REGION

National Council on the Aging
Lincoln Building
60 East 42nd Street, Suite 1465
New York, NY 10017

SOUTHEAST REGION

National Council on the Aging
Rhodes-Haverty Building, Suite 1220
134 Peachtree Street, NW
Atlanta, GA 30303

WESTERN REGION

National Council on the Aging
1182 Market Street, Room 417
San Francisco, CA 94102

WEST COAST MEDIA OFFICE

National Council on the Aging
7461 Beverly Boulevard
Los Angeles, CA 90036

NATIONAL COUNCIL ON FAMILY RELATIONS
1219 University Avenue Southeast
Minneapolis, Minnesota 55414

NATIONAL GERIATRICS SOCIETY, INC.
212 W. Wisconsin Ave.
Milwaukee, WI 53202

NATIONAL HEALTH COUNCIL, INC.
1740 Broadway
New York, NY 10019

NATIONAL INDIAN COUNCIL ON AGING
PO Box 2088
Albuquerque, NM 87103

NATIONAL INSTITUTE OF SENIOR CENTERS
c/o National Council on Aging
1828 L Street, NW
Washington, DC 20036

NATIONAL RURAL HEALTH COUNCIL OF RURAL AMERICA
1346 Connecticut Avenue, NW
Washington, DC 20036

NATIONAL URBAN LEAGUE
500 E. 62nd Street
New York, NY 10021

NATIONAL VOLUNTARY ORGANIZATION FOR
INDEPENDENT LIVING OF THE AGED
c/o National Council on Aging
1828 L Street, NW
Washington, DC 20036

NOW TASK FORCE ON OLDER WOMEN
6412 Telegraph Avenue
Oakland, CA 94609

RETIREMENT HOUSING FOUNDATION
555 E. Ocean Blvd.
Long Beach, CA 90802

SOCIETY FOR HEALTH AND HUMAN VALUES
925 Chestnut Street 6th Floor
Philadelphia, PA 19107

SPECIAL COMMITTEE ON AGING
U.S. Senate Room G-225
Dirksen Senate Office Building
Washington, DC 20510

U.S. DEPARTMENT OF COMMERCE - SOCIAL & ECONOMICS
STATISTICS ADMINISTRATION, BUREAU OF THE CENSUS
Suitland, MD 20233

UNITED STATES JAYCEES
4 W. 21st Street
Tulsa, OK 74102

UNITED WAY OF AMERICA, NATIONAL OFFICE
801 North Fairfax Street
Alexandria, VA 22314

UNITED WAY OF AMERICA, SOUTHEAST REGIONAL OFFICE
2150 Parklake Drive
Suite 310
Atlanta, GA 30345

URBAN ELDERLY COALITION
828 L. Street NW Suite 505
Washington, DC 20036

VOLUNTEERS OF AMERICA
340 W. 85th Street
New York, NY 10024

IV. Private Foundations which are Supportive of Programs and Research

THE BODMAN FOUNDATION
[illegible]0 Park Avenue
New York,NY 10022

CHAS E. CULPEPPER FOUNDATION
866 UNITED NATIONS PLAZA
New York, NY 10017

DORIS DUKE FOUNDATION
Duke Forms
Rt. 206
Somerville, NY 08876

FLORENCE V. BURDEN FOUNDATION
630 Fifth Avenue
New York, NY 10020

FOREST PARK FOUNDATION
600 Commercial National Bank Bldg.
Peoria, IL 61602

HARTFORD FOUNDATION FOR PUBLIC GIVING
45 South Main
West Hartford,CT 06107

J. H. SHEADLE TRUST
900 Euclid Ave
Cleveland,OH 44101

J. M. MCDONALD FOUNDATION
Werner-Whelan Plaza
P O Box 202
Hastings, Nebraska 68901

J. WALTON BISSELL FOUNDATION
29 Ten Acre Lane
West Hartford,CT 06107

THE KALAMAZOO FOUNDATION
[illegible]2 ISB Bldg
[illegible]1 So. Rose Street
Kalamazoo, MI 49006

THE KRESGE FOUNDATION
2401 Big Beaver Road
Troy, MI 48084

THE LETTIE PATE WHITEHEAD FOUNDATION
1400 Peachtree
Center Tower
230 Peachtreet Street, NW
Atlanta, GA 30303

THE LUKE B. HANCOCK FOUNDATION
300 Sandhill Road
Menlo Park, CA 94025

THE MCGREGOR FUND
2026 Commonwealth Bldg
Detroit, MI 48226

ROSAMOND GIFFORD CHARITABLE CORP.
501 Orandage Savings Bank Building
Syracus, NY 13202

SEARS Roebuck FOUNDATION
Sears Tower
Chicago, IL 60684

US STEEL FOUNDATION
600 Grant Street
Pittsburgh, PN 15230

WALTER H.D. Kellogg TRUST
250 Park Avenue
New York, NY 10017

WILLIAM G. SELBY AND MARION SELBY FOUNDATION
P O Box 2018
Sarasota, FL 33578

Reference: Steibe, Chas. A Directory of Resources for Aging, Gerontology and Retirement.
Mankato Minnisota: Scholarly Press, 1979.

V. Professional Organizations of North Carolina

CAPITAL AREA PROFESSIONAL STANDARDS REVIEW ORGANIZATION, INC.
3700 Computer Drive
P O Box 18805
Raleigh, NC 27609

HOSPICE OF NORTH CAROLINA
P O Box 8837
Durham, NC 27707

MENTAL HEALTH ASSOCIATION OF NC
3701 National Drive
Raleigh, NC

NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS
1002 Wake Forest Road
Drawer 11268
Raleigh, NC 27604

NORTH CAROLINA ASSOCIATION OF HOMES FOR THE AGED
Branch Bank and Trust Bldg.
Raleigh, NC

NORTH CAROLINA COUNCIL OF FAMILY SERVICE AGENCIES
301 S. Broad Street
Charlotte, NC 28202

NORTH CAROLINA COUNCIL OF HOME HEALTH AGENCIES
714 Ninth Street
Durham, NC

NORTH CAROLINA DENTAL SOCIETY
2414 Wycliff Road
Raleigh, NC 27607

NORTH CAROLINA HEALTH CARE FACILITIES ASSOCIATION
111 Corcoran Street
Durham, NC 27701

NORTH CAROLINA HOSPITAL ASSOCIATION
112 Cox Avenue
Raleigh, NC

NORTH CAROLINA HOSPITAL EDUCATION AND RESEARCH FOUNDATION, INC.
112 Cox Avenue
Raleigh, NC

NORTH CAROLINA LEAGUE FOR NURSING
P O Box 10683
Raleigh, NC

NORTH CAROLINA LICENSED PRACTICAL NURSE ASSOCIATION
214 South Driver Street
P O Box 11407
Durham, NC 27703

NORTH CAROLINA MEDICAL PEER REVIEW FOUNDATION, INC.
P O Box 19047
Raleigh, NC 27609

NORTH CAROLINA MEDICAL SOCIETY
222 N. Person Street
Raleigh, NC

NORTH CAROLINA NURSES ASSOCIATION
103 Enterprise Street
P O Box 12024
Raleigh, NC 27605

NORTH CAROLINA PHYSICAL THERAPY ASSOCIATION
600 Wade Avenue
Raleigh, NC 27605

NORTH CAROLINA PUBLIC HEALTH ASSOCIATION
P O Box 10587
Raleigh, NC 27605

NORTH CAROLINA SOCIAL SERVICES ASSOCIATION
204 North Person Street
Raleigh, NC 27601

NORTH CAROLINA STATE NURSES ASSOCIATION
P O Box 12025
Raliegh, NC 27605

SOCIETY FOR HEALTH EDUCATION, NORTH CAROLINA
P O Box 86
Wade, NC 28395 (good for 1980)

VI. Other Organizations and Associations Serving the Elderly in North Carolina

ALTRUSA INTERNATIONAL
817 York Street
Gastonia, NC 28052

AMERICAN ASSOCIATION OF RETIRED PEOPLE
Route 3
Brevard, NC 28712

AMERICAN CANCER SOCIETY, NC DIVISION
Box 27624
Raleigh, NC 27611

AMERICAN RED CROSS
2425 Park Road
Charlotte, NC

BETTER TRANSPORTATION FOR NORTH CAROLINA, INC.
3203 Womans Club Drive
Raleigh, NC 27612

COMMON CAUSE/NORTH CAROLINA
P O Box 482
Raleigh, NC

COORDINATION COUNCIL FOR SENIOR CITIZENS
519 Main Street
Durham, NC 27701

DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS WATS LINE
1-800-662-7777

DUKE CENTER FOR THE STUDY OF AGING
Institute for Learning in Retirement
Bivens Bldg.
Duke University
Durham, NC 27708

MEDICARE OF NORTH CAROLINA
The Prudential Insurance Co. of America
P O Box 2126
High Point, NC 27261

NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS
P O Box 1488
Raleigh, NC 27602

NORTH CAROLINA CITIZENS ASSOCIATION
336 Fayetteville Street
P O Box 2508
Raleigh, NC 27602

NORTH CAROLINA CITIZENS FOR PUBLIC HEALTH
School of Public Health, UNC
Chapel Hill, NC 27514

NORTH CAROLINA CIVIL LIBERTIES UNION
P O Box 3094
Greensboro, NC 27402

NORTH CAROLINA CONFERENCE FOR SOCIAL SERVICE, INC.
Room 1, 613 West North Street
Raleigh, NC 27602

NORTH CAROLINA COUNCIL OF CHURCHES
208 East Duke Street
Durham, NC 27708
and
Bryan Building
201A Cameron Village
Raleigh, NC 27605

NORTH CAROLINA FEDERATION OF WOMEN'S CLUBS
3509 Hayworth Drive
Raleigh, NC

NORTH CAROLINA HEART ASSOCIATION
P O Box 2408
1 Heart Circle
Chapel Hill, NC

NORTH CAROLINA LIONS ASSOCIAITON FOR THE BLIND
Gateway Plaza
Raleigh, NC

NORTH CAROLINA JAYCEES
P O Box 1323
Ashesboro, NC 27203

NORTH CAROLINA RETIRED GOVERNMENTAL EMPLOYEES ASSOCIATION
715 West Johnston Street
P O Box 10561
Raleigh, NC 27605

NORTH CAROLINA-SOUTH CAROLINA LIBRARY FOR THE BLIND AND PHYSICALLY HANDICAPPED
Jefferson Street
Raleigh, NC

NORTH CAROLINA STATE GRANGE
437 W. Friendly Avenue
Box G-1
Greensboro, NC 27402

NORTH CAROLINA UNITED WAY
301 South Brevard Street
Room 316
Charlotte, NC 28202

SCORE
Northwestern Bank Building
230 South Tryon Street
Suite 200
Charlotte, NC 28202

STATE COUNCIL FOR SOCIAL LEGISLATION
509 Spring Valley Drive
Raleigh, NC 27609

WOMEN'S EQUITY ACTION LEAGUE
2507 Sevier Street
Durham, NC

REFERENCES

With the exception of Section IV (Private Foundations) the Organizational resources listed here were compiled from the following resources:

Cole, Elma P. 1978 Service Director of National Voluntary Health and Social Welfare Organizations. New York: National Assembly of National Voluntary Health and Social Welfare Organization, Inc. 1978.

Farley, Lacy and Betty Farley (Eds.) 1980-81 National Director of Health/ Medicine Organizations Maryland: Science and Health Publications, Inc. 1980

Kruzas, A.T. (Ed.) Medical and Health Information Directory. Detroit, Michigan: Gale Research Company Book Tower. 1977.

North Carolina Directory of Business, Professional and Civic Organizations, 1979-1980. P.O. Box 9006 Charlotte, NC 28299.

North Carolina State Capitol Telephone Directory. Raleigh, NC: Department of Administration Spring, 1980.

Marquis Academic Media Sourcebook on Aging, Chicago: Marquis Who's Who, Inc. 1979.

APPENDIX C

GUIDE TO STATISTICAL INFORMATION

I. NATIONAL DATA SOURCES

The federal government supports numerous research projects and compiles utilization statistics for a number of government programs. The following listing includes addresses and brief descriptions of federal agencies which produce reference materials in the following areas:

- population demography and health
- availability and utilization of health care resources.

U.S. BUREAU OF THE CENSUS
Demographic Census/Demographic Surveys Division
Department of Commerce
Washington, DC 20233

The Census Bureau conducts a survey of the entire population of the United States every ten years. Housing surveys are conducted annually as well as during the decennial population census. Each month, the Current Population Survey samples households nationwide to provide unemployment estimates. An expanded version, including a wide range of demographic items, is conducted each March. The Census Bureau conducts a number of other surveys to obtain information on business and economic variables, state and local governments, etc.

ADMINISTRATION ON AGING (AoA)
330 Independence Ave. SW
Washington, DC 20201

AoA's National Clearinghouse on Aging provides a number of publications containing statistical information on elderly persons in the United States. Two publications of particular interest are: "Inventory of Federal Statistical Programs on Older People" and "The Elderly: Estimates by County."

NATIONAL CENTER FOR HEALTH STATISTICS
Office of Health Research, Statistics and Technology
U.S. Dept. of Health and Human Services
3700 East-West Highway
Hyattsville, MD 20782

A number of surveys are conducted which generate vital statistics, general population health information, availability of health resources, and health resources utilization (See reference below to obtain descriptions of studies).

HEALTH CARE FINANCING ADMINISTRATION

Office of Beneficiary Services
2424 Oak Meadows
Baltimore, MD 21207

Research, Demonstrations, and Statistics
Dept. of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

In addition to collecting utilization and expenditure statistics for the Medicare and Medicaid programs, HCFA conducts other studies related to health care (e.g. annual surveys of health insurance plans; PSRO hospital discharge surveys). Monthly Medicare statistics are published in the Social Security Bulletin (some statewide statistics are available).

SOCIAL SECURITY ADMINISTRATION
Office of Research and Statistics
U.S. Dept. of Health and Human Services
1875 Connecticut Ave. NW
Washington, DC 20009

Benefit information on SSI and Social Security is compiled. See the monthly Social Security Bulletin for figures on expenditures and utilization (some statewide statistics are available).

VETERANS ADMINISTRATION
810 Vermont Ave. NW
Washington, DC 20420

The VA publishes statistics on the compensation and pension system as well as statistics on utilization of health care services.

CONGRESSIONAL COMMITTEES

The House and Senate each have a committee devoted to the examination of issues involving Older Americans. A list of publications (e.g. hearings, special reports) can be requested from each committee.

U.S. Senate Special Committee on Aging
United States Senate
Washington, DC 20510

U.S. House Select Committee on Aging
U.S. House of Representatives
Washington, DC 20515

Useful references

STATISTICAL ABSTRACT OF THE UNITED STATES
Washington, DC
U.S. Government Printing Office
(Published annually)

Includes statistics on population, vital statistics, health and nutrition, education, social insurance and welfare, economic variables, etc.

U.S. BUREAU OF THE CENSUS, DEPARTMENT OF COMMERCE
"Directory of federal statistics for local areas. A guide to sources; 1976" and "A guide to sources: Urban update, 1977-78."

Includes statistics in the following areas: population, housing, income, vital statistics and health, economic variables, governments, etc.

U.S. PUBLIC HEALTH SERVICE, NATIONAL CENTER FOR HEALTH STATISTICS, DHHS.
"Data systems of the National Center for Health Statistics."
Hyattsville, MD.
DHEW Pub. No. (PHS) 80-1247.

U.S. BUREAU OF THE CENSUS AND ADMINISTRATION ON AGING
"Guide to Census data on the elderly." Washington, D.C.: U.S. Government Printing Office. September, 1978.

This guide is designed to ease the process of locating Census data on the elderly which is available in the form of printed reports, computer tapes, and special tabulations. The availability of population data (general and social characteristics, economic characteristics and housing data is indicated for the following geographic areas: Nation, region, state, Standard Metropolitan Statistical Area (SMSA), county, place, and census tract.

II. STATE DATA SOURCES

NORTH CAROLINA STATE DATA CENTER

The State Data Center is a new Federal-State cooperative effort designed to improve access to and use of statistical resources and analysis for administration, decision-making, planning, and research. Established through an agreement between the State of North Carolina and the United States Bureau of the Census, the State Data Center provides services to state and local governmental personnel, business and industry leaders, university educators and researchers, community organization leaders, planners, and other data users.

The State Data Center provides service in North Carolina through a consortium composed of the North Carolina Division of State Budget and Management, the State Library, and the Institute for Research in Social Science, University of North Carolina - Chapel Hill. The State Data Center also provides services throughout North Carolina with a network of regionally affiliated data centers designed to extend the access of the State Data Center's printed resources to city and county levels. Regional Data Centers currently consist of ten local libraries across the state.

Products and services provided by the Census Bureau and located in the State Data Center include all the Bureau's major statistical programs in printed form and/or on computer tapes. The State Data Center also houses statistical reports generated by State Agencies which will supplement and be integrated with Census Bureau products in order to facilitate analysis.

For more information contact: Karen Bunn/Paul Crissman/Bob Overby, Division of State Budget, 116 West Jones Street, Raleigh, NC 27611, Telephone 919/733-7061.

COMMUNITY PROFILE SYSTEM

The Department of Natural Resources and Community Development in North Carolina has designed a computerized information system containing data about the state's counties, towns, and communities. The Community Profile System, consisting of four distinct data bases,(including a needs assessment conducted by the Center for Urban Affairs at N.C. State which is used for Title XX planning) is available to planners and decision-makers throughout the state. Telephone linkage allows accessibility to the data via computer terminal.

For more information contact: Hugh Rollins, CPS Program Director, Office of Community Development, Department of Natural Resources and Community Development, Raleigh, NC 27611, Telephone 919/733-2857.

THE NORTH CAROLINA STATE HEALTH PLAN

Each year, a health plan for the state is approved by the North Carolina coordinating Council (SHCC). A separate body, the State Health Planning and Development Agency (SHPDA), under the Department of Human Resources, reviews plans submitted by each Health Systems Agency in the state and analyzes state level data and policies. On the basis of this process, a preliminary plan is submitted to SHCC for approval. The final North Carolina State Health Plan provides an overview of health status needs of the state's population plus a discussion of projected needs in various components of the health care system (e.g. preventive services, long-term care).

AREA AGENCIES ON AGING AND THE STATE DIVISION OF AGING

The Area Agencies on Aging in each Multi-County Planning Region compile utilization statistics on services mandated by the Older Americans Act. Each year, the Area Agencies submit an Area Plan to the Division on Aging which includes information about demographics and needs of the service population and subsequent services delivery. The Division on Aging assesses each plan and plan incorporates the findings into the statewide planning process.

OFFICE OF BUDGET AND MANAGEMENT

In addition to the operation of the State Data Center, making computerized data available, the Office of Budget and Management engages in data collection and publishes statistical information for public use. For example the office conducts the annual North Carolina Citizens Survey in which data on the status of health and economic development of the state is obtained. A useful reference document containing data generated by by state agencies is published bienially (See reference to the Statistical Abstract below). A guide to data sources within North Carolina government agencies is also published every other year (See reference to the Statistical Guide below). Contact the following office for a list of publications: Library, Office of State Budget and Management Research and Planning Services, 116 West Jones Street, Raleigh, NC 27611.

Useful references

Birdsall, S.S., Hallman, S.P. and Kopec, R.J. North Carolina Atlas of Elderly. University of North Carolina, Chapel Hill. Social Research Section, Division of Health Affairs and Department of Geography. 1979.

Clay, J.W. Orr, D.M. and Stuart, A.W. (Eds.), North Carolina Atlas; Portrait of a Changing Southern State. Chapel Hill: University of North Carolina Press, 1975.

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